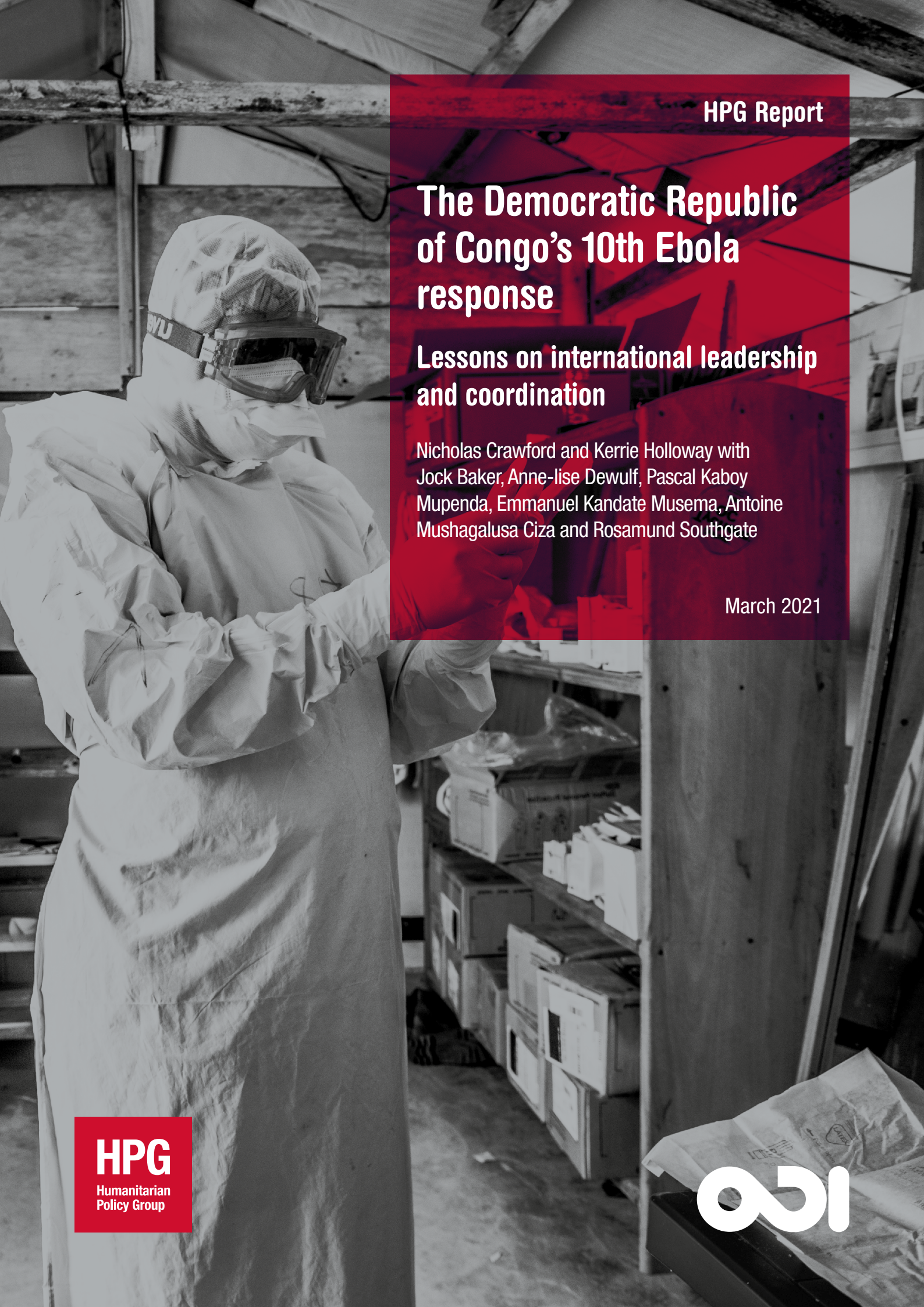

HPG Report

The Democratic Republic of Congo's 10th Ebola response

Lessons on international leadership and coordination

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Acronyms

AAP	Accountability to Affected Populations
ANR	DRC National Intelligence Agency
CAC	cellules d'animations communautaires (community action cells)
CASS	Cellule d'Analyse en Science Social (Social Science Research Unit)
CBPF	Country-based Pooled Fund
CDC	United States Center for Disease Control
CERF	Central Emergency Response Fund
DRC	Democratic Republic of Congo
ECDC	European Centre for Disease Prevention and Control
EERC	Ebola Emergency Response Coordinator
EERO	Ebola Emergency Response Office
EERT	Ebola Emergency Response Team
ERC	Emergency Relief Coordinator
ETC	Ebola Treatment Centre
EVD	Ebola Virus Disease
FARDC	Armed Forces of the DRC
FSRDC	Social Fund of the DRC
FTS	Financial Tracking Service
GOARN	Global Outbreak Alert and Response Network
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team

HPG	Humanitarian Policy Group
IASC	Inter-Agency Standing Committee
IDP	internally displaced person
IFRC	International Federation of Red Cross and Red Crescent Societies
IHR	International Health Regulations
IMS	Incident Management Structure
INGO	international non-governmental organisation
IOAC	Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme
IOM	International Organization for Migration
JMAC	Joint Mission Analysis Centre
LNGO	local non-governmental organisation
MoH	Ministry of Health
MONUSCO	United Nations Organization Stabilization Mission in the DRC
MSF	Médecins Sans Frontières
NGO	non-governmental organisation
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PDSS	Health System Development Programme
PEF	Pandemic Emergency Financing Facility
PNC	Congolese National Police
PSEA	protection from sexual exploitation and abuse
RC	Resident Coordinator
RCCE	risk communication and community engagement
RECO	relais communautaire (community health volunteers)
RISD	Research Initiatives for Social Development
SAGE	Strategic Advisory Group of Experts on Immunization

SEA	sexual exploitation and abuse
SRP	Strategic Response Plan
SRSG	Special Representative of the Secretary-General
SSHA	Social Science in Humanitarian Action
UN	United Nations
UNDP	UN Development Programme
UNDSS	UN Department for Safety and Security
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
UNMEER	UN Mission for Ebola Emergency Response
USAID	United States Agency for International Development
WFP	World Food Programme
WHO	World Health Organization

Executive summary

On 1 August 2018, the Ministry of Health (MoH) of the Government of the Democratic Republic of Congo (DRC) declared the country's 10th outbreak of Ebola Virus Disease (EVD) in North Kivu – an outbreak that would last until June 2020. It became the largest Ebola outbreak the DRC had experienced, and the second largest in the world. Overall leadership and coordination of the EVD response rested with the Government of DRC, with significant financial, technical and operational support from the international community, led by the World Health Organization (WHO).

The government and its partners successfully controlled the outbreak after 22 months – much later than originally expected and only after significant, and belated, corrections to the response's leadership and coordination model, as well as recalibrations to the response strategy. Combatting an Ebola outbreak in densely populated areas, among a highly mobile population with no previous experience of the disease, and in a context characterised by decades of violence and armed conflict and ongoing acute humanitarian needs was a major challenge.

This case study focuses on the international leadership and coordination of the EVD 10 response in DRC. It considers the extent to which the government's key international partners enabled and shaped the government-led response. It also explores the effectiveness of international leadership in the complex context of eastern DRC, and the extent to which lessons from the 2014–2016 West Africa Ebola outbreak were successfully applied. The study aims to identify lessons and recommendations to inform similar future responses.

Overall, international leadership and coordination was slow to organise an inclusive and coordinated response among the range of international actors – WHO, United Nations (UN) agencies, the UN Organization Stabilization Mission in the DRC (MONUSCO), international non-governmental organisations (INGOs), the International Federation of Red Cross and Red Crescent Societies (IFRC), donors and the World Bank – who would eventually contribute to collective efforts to overcome the outbreak. A gradual emphasis on greater inclusiveness, especially with regard to local actors, eventually led to a harmonised purpose among the responders. More formal adjustments in international leadership and coordination structures – such as the appointment of a UN-mandated Ebola Emergency Response Team (EERT) – helped accelerate these positive changes, but they were not the key drivers of them.

Despite early recognition by those working on the ground that the MoH–WHO response model (imported from the successful EVD 9 response in western DRC) was ill-suited to the security, health system and cultural challenges of the affected region, months would pass – with infections rising, armed groups more directly targeting response staff and structures, and communities hardening their resistance to the response – before a fundamental re-assessment of strategy was considered. Attempts to correct early missteps were only partially successful. Failure on the part of collective international leadership to adequately analyse and manage risks from the outset, and to plan for and adapt along the way to the challenging context, contributed to profoundly negative impacts on outcomes related to community engagement, security approaches and sound financial management. These missteps are likely to have lasting implications for future responses and international humanitarian action in the affected region and throughout the country.

The early decision by the government and WHO to treat EVD 10 as a discrete public health crisis (or health security crisis) rather than a crisis-within-a-crisis – i.e. one health

priority among many; one threat to the community among many – set the tone for poor synergy between health actors and humanitarian actors throughout the entirety of the response. As a result, overall accountability to affected populations (AAP), including measures for the prevention of sexual exploitation and abuse (PSEA), received less attention than it should have. There was also insufficient attention to humanitarian principles and the risks that ignoring these principles posed for response staff and affected communities. A deliberate layering of the Ebola response within a larger public health and humanitarian response was never achieved, and accountability for important shortcomings of the response – beyond the control of the disease itself – remained diffused and unclear.

Recommendations[1] for international leadership and coordination

1. Leadership and coordination structures need to avail themselves of the assets, resources and knowledge in place in country from the outset. There is no room for a 'go-it-alone' approach in a complex setting. The UN Resident or Humanitarian Coordinator (RC/HC), with support from the UN Office for the Coordination of Humanitarian Affairs (OCHA) and WHO, should lead and unequivocally assume responsibility and accountability for future outbreak responses in complex emergency settings.
2. WHO needs an improved response model to respond effectively in **fragile contexts** where governments either lack capacity and/or are parties to the conflict. This should be designed in conjunction with reviewing WHO's Incident Management Structure (IMS) system and ensuring optimal use of health cluster structures, with a view to ensuring flexibility and collaboration with partners in unpredictable contexts as well as the right mix of capacities and abilities in deployments.
3. Strengthening leadership and coordination capacity should be done based on existing structures – specifically the RC/HC office (possibly through a Deputy HC) and OCHA, including the cluster system. Parallel structures should be avoided. In exceptional circumstances or when the UN Country Team and Humanitarian Country Team (HCT) are overwhelmed with other crises in a country, the Inter-Agency Standing Committee (IASC) Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events provides a solid basis for considering adjustments in leadership.
4. The IASC Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events needs to be revised to ensure it is considered fully at an early stage and that its reconsideration is triggered whenever commonly agreed thresholds are reached.
5. Operationalisation of the Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events should be improved through well-defined standby agreements – and possibly joint trainings – between WHO and key agencies with complementary capacities.
6. The World Bank should consider the appointment of a Bank 'Senior Emergency Coordinator' in future responses where Bank resources – whether channelled through governments or directly to implementing agencies – comprise a significant proportion of response funding.
7. Following IASC guidance, a PSEA mechanism should be set up at the onset of an emergency, adhere to the minimum operating standards and link to pre-existing mechanisms in country to avoid duplication and meet community needs (IASC, 2016). Moreover, a greater attempt at gender parity in both leadership and operational roles is needed to ensure that greater attention is paid to gender issues, including sexual exploitation and abuse.

1 Some of the recommendations presented here have been summarised. Full recommendations are found in chapter 6 of the report.

Recommendations for community engagement

1. Successful community engagement must be tailored to the specific context of the outbreak and grounded in local communities and community organisations, including existing health structures. WHO and its partners need to re-commit to community engagement that relies on two-way communication between the community and the response team.
2. Community engagement strategies need to embrace a broader AAP framework – that is, they need to go beyond addressing people's risk of contracting or spreading Ebola to considering their overall protection and well-being, including their other health needs.

Recommendations for security

A more nuanced security approach, striving for 'security by acceptance' and opting only when necessary for 'security by protection', should be employed in future responses in complex settings. Sometimes these approaches will need to be pursued simultaneously. Security strategies should be built around conflict analysis, stakeholder mapping, networking and humanitarian and transactional negotiation in order to mitigate risks when armed escorts are needed.

Recommendations for the management of resources

1. Future responses should establish from the outset systems to help ensure transparent, accountable and efficient use of resources. Future response should consider using a mutual accountability framework. Pooled fund mechanisms and dedicated financial tracking and management capacity (e.g. for staff employment and salary payments) – a lesson from the West Africa Ebola response – should be implemented.
2. Careful consideration should be given to the scale of payments made to communities to encourage their participation in a response, which in theory should be based on volunteerism or basic per diems at most (as is the case with Congolese Red Cross volunteers).

Recommendations for balancing a public health and humanitarian response

1. WHO, as a public health technical lead, cannot be expected to also shoulder full accountability for the UN in a fragile, conflict-affected setting across a range of complex operational, security, political and community engagement issues. These lines of accountability – e.g. on security, on appropriate PSEA mechanisms – need to be agreed to the extent possible at the outset of a response under the authority of the RC/HC, preferably as part of arrangements agreed during the early consideration of the Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events.
2. A true public health response aligns with the humanitarian principles of humanity, impartiality, neutrality and independence, as well as 'do no harm'. Both a public health response and a humanitarian response should focus on the overall well-being of the individual, the family and the community and go beyond an exclusive focus on a specific disease and its eradication.
3. Future Ebola outbreaks should be dealt with as part of a community's overall health needs. Short-term 'global health security' fears – with outcomes designed around a focus on stopping the spread of the disease to the Global North – should be complemented by a focus on better and sustainable public health in DRC.

Recommendations to donors

1. Donors need to redouble their efforts to make humanitarian contributions more flexible and to make development financing accessible, in the context of ongoing financing efforts around the 'nexus' and localisation.
2. Donors need to reconsider the suitability of channelling resources through the World Bank for responses in complex humanitarian settings, especially when those same donors object to financing the government directly because of corruption or capacity worries.
3. Donors should continue to deploy staff to emergency responses in order to foster better understanding and communication between the donor community, the government and response agencies. But donors need to revisit their security protocols to ensure that their staff is deployed in the same locations as public health or humanitarian agency staff. An alternative would be to contract trusted third parties who are not subject to the same security constraints.

1 Introduction

On 1 August 2018, the MoH of the Government of DRC declared the country's 10th outbreak of EVD in North Kivu. By the time the outbreak was declared over on 25 June 2020, 3,481 people had been infected, of whom 2,299 died – the largest ever outbreak in DRC and the second largest in the world after the West African outbreak of 2014–2016 (WHO, 2020).

Overall leadership and coordination of the EVD response was in the hands of the Government of DRC, which brought significant technical and operational experience to the task, having successfully contained nine previous outbreaks in the country since Ebola was first identified there in 1976. What first seemed like it might be another small and relatively isolated outbreak[2] quickly grew in size and complexity, challenging the government's ability to contain the virus and testing its leadership and coordination capacities.

As the disease progressed, government strategies were adjusted through a series of Strategic Response Plans (SRPs). Eventually, government leadership of the response was transferred from the MoH to the Office of the President. Only after 22 months of demanding work – with significant financial, technical and operational support from the international community, led by WHO – could the government announce that the virus outbreak was contained.

Getting the disease under control was a significant achievement. The government managed to limit and control EVD 10 in densely populated areas, among a highly mobile population with no previous experience of the disease. The area had long been characterised by decades of violence and armed conflict as well as weak health structures and ongoing acute humanitarian needs. The spread of EVD was exacerbated by armed attacks that impeded response teams as well as community resistance. At the start of the outbreak, more than a million displaced people were hosted in North Kivu – 25% of the country's population of internally displaced people (IDPs) (ACAPS, 2018). The epidemic did not cross over DRC's porous borders into neighbouring countries such Uganda and Rwanda in significant numbers, thereby reducing the threat of the disease at the regional and international level.[3] Overall accountability for the response rests with the Government of DRC – both for the successful control of the outbreak, for the stumbles in implementation and for the collateral and residual damages as a result of the response.

1.1 Purpose of the study

This purpose of this case study is to examine the effectiveness of international leadership and coordination in supporting the EVD outbreak response and to identify lessons and recommendations to inform similar future responses. The study considers the extent to which international partners, through their evolving leadership and coordination structures, enabled and shaped the government-led response. In particular, it looks at the impact international leadership and coordination had on outcomes related to (1) community engagement and acceptance; (2) the management of response resources; and (3) the security of affected populations and response staff. It also aims to

2 The mean case count of previous outbreaks was 126 (IOAC, 2019a).

3 There were four imported cases of Ebola into Uganda in the summer of 2019. All four had recently travelled from the DRC into Uganda (Beaumont and Okiror, 2019).

draw lessons from how international partners deployed their expertise and assets in order to help shape future responses – particularly in contexts where a public health emergency overlaps with an ongoing, complex humanitarian crisis.

1.2 Methodology

This case study comprises a desk review of literature on this and previous EVD outbreaks and 128 interviews with key informants in DRC and globally who work for the UN, including WHO; other health organisations; INGOs; local non-governmental organisations (LNGOs), including national NGOs; local and national government officials; and donors, including the World Bank (see Table 1). Interviews and an analysis workshop were held with the project's reference group, whose members represent a range of key stakeholders. The data underpinning this report was collected between July and November 2020 by research teams at the Humanitarian Policy Group (HPG), based in London, and at Research Initiatives for Social Development (RISD), based in South Kivu, DRC.

The study is not an evaluation of the overall EVD response; instead it is a case study that draws out specific lessons to be applied in future, similar responses. The key research questions focused on international leadership and coordination. The methodology for the study included pre-agreed, objective 'judgement criteria' for each of the study questions to ensure a robust approach to data analysis and determination of findings (see Annex 1). The study captures reflections from stakeholders recently engaged in the response and could lay the groundwork for potential forthcoming evaluations of the EVD 10 response.

Table 1: Interviews conducted

Organisation type	Interviews
UN agencies, including WHO	38
Other health organisations	6
INGOs	21
LNGOs	26
Government of DRC	15
Donors	22
Total	**128**

The research team encountered some challenges in gathering and analysing evidence. The case study focuses on international leadership and coordination performance and lessons, which are not topics that lend themselves easily to measurement through quantifiable indicators. The study team relied on the group and individual perceptions of a wide range of stakeholders to draw conclusions and lessons. This is equally true for conclusions and recommendations around (1) the impact of international leadership and coordination on community engagement and acceptance; (2) the management of response resources; and (3) the security of affected populations and response staff. The team used triangulation as a key tool during the study to ensure a robust evidence base to develop and test emerging conclusions – combining information from different secondary data and different categories of interviewees.

2 Background to the Outbreak 10 response

The first confirmed cases of EVD were identified in Mangina in North Kivu, where the virus had likely already been spreading, and claiming victims, since mid-May 2018 (Congo Research Group, 2020). By the middle of July, 5–10 people were dying of Ebola-like symptoms every day in Mangina before health authorities in Kinshasa were finally alerted and laboratory samples confirmed the outbreak. Although delayed in raising the initial alert, the Government of DRC, through the MoH, then launched into action with the support of WHO – this constituted the first phase of the response (see Figure 1).

The initial delay in recognising and confirming the first cases of EVD in Mangina point to several underlying contextual factors that would shape – and hamper – response efforts over the subsequent 22 months. First, the population was unfamiliar with Ebola, as this was the first Ebola epidemic in North Kivu – far from the previous nine outbreaks. Second, the capacity of local health structures was weak, with doctors and nurses lacking basic knowledge about the disease and clinics lacking basic equipment, including personal protective equipment. Third, the region has experienced decades of violence and armed conflict, with ongoing acute humanitarian needs (see Box 1). Finally, local medical staff and the community had little faith in the ability or willingness of outside authorities to come to their aid and a general distrust of the national government (Congo Research Group, 2020). This distrust extended beyond government officials to aid workers and researchers, who were also suspected of trying to profit from the outbreak (Nature, 2019). As the disease spread across the region and into more urban areas, resistance related to this distrust of outsiders, especially national authorities, also grew.

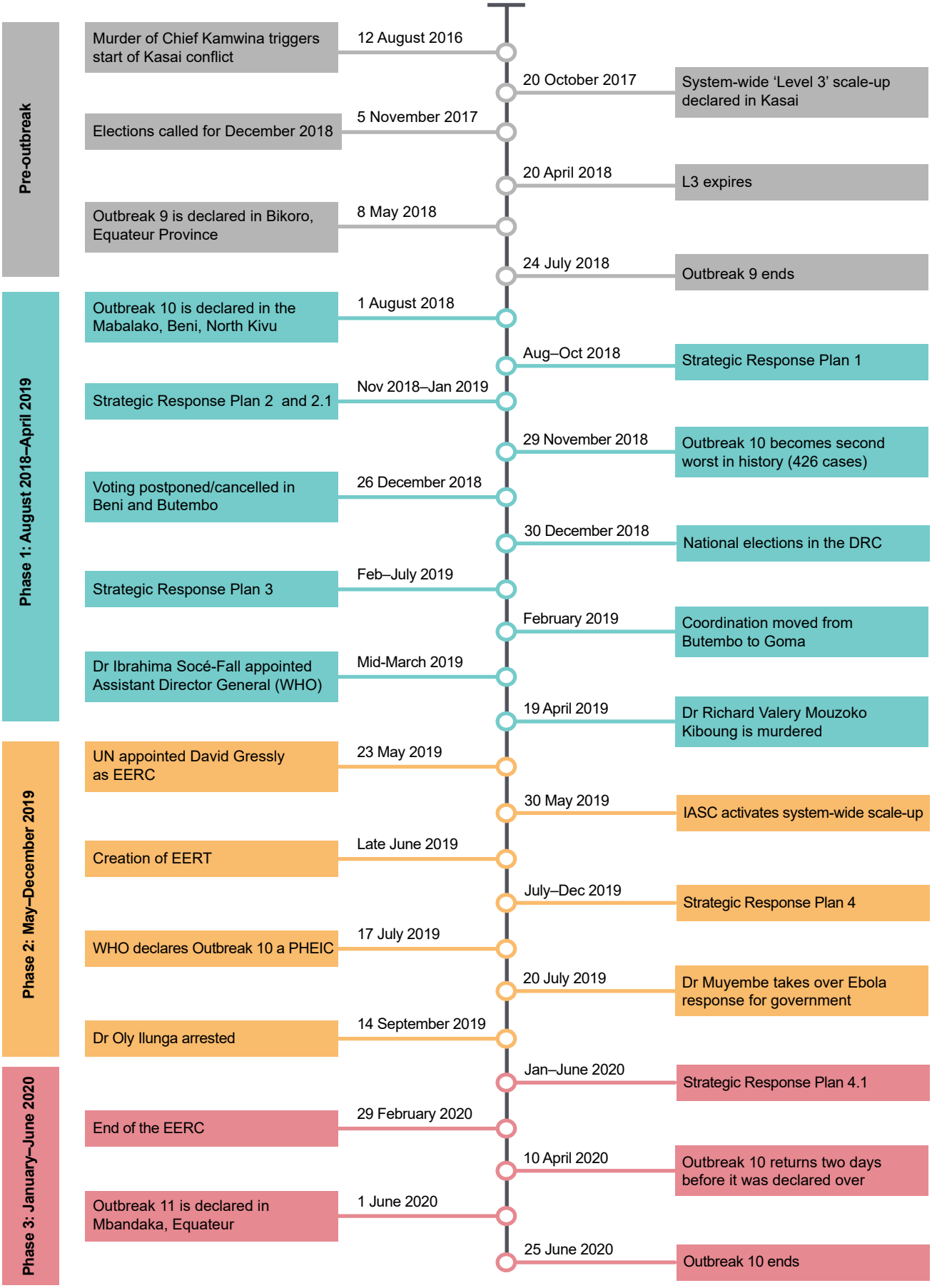
2.1 Phase 1: early efforts replicate the 9th outbreak response model

Building on its successful containment[4] of EVD 9 in Equateur region (declared over after only three months on 24 July 2018), the government embarked on 'the fastest, best equipped, and best-funded [response] in the history of Ebola outbreak response' to deal with EVD10 (IOAC, 2019a: 40). A Strategic Response Plan (SRP1), covering the period August–October 2018, defined the response model, with coordination structured as in past responses, around eight pillars of action: surveillance (including contact tracing, points of entry and vaccination), laboratories, case management, risk communication and community engagement (RCCE), psychosocial support, infection prevention and control (including safe and dignified burials), logistics and security.

Soon after the outbreak was declared, the MoH began administering an experimental vaccine (Merck's rVSV-ZEBOV, unlicensed but shown to be protective in trials in the latter stages of the West Africa outbreak); and by

4 While EVD 9 was successfully contained, many interviewees made comments like 'they got lucky' and did not feel that the response model had been adequately tested, as the 9th outbreak occurred in a rural setting, which was easily isolated and without the conflict context of EVD 10. Other interviewees believed cracks were already showing in the 9th response that were not sufficiently addressed when the response ended, due to the short amount of time between the end of EVD 9 and the beginning of EVD 10.

Figure 1: Timeline of the response



Box 1: Insecurity and conflict in the Grand-Nord and the DRC

The depth of hostility in the Grand-Nord of North Kivu – and among the Nande ethnic group, which comprises the overwhelming majority of the population – for the central government and its representatives should not be understated. Since at least the Mobutu era, the Nande have nursed grievances with the central government and have worked to establish economic, if not political, autonomy for the area including through strong trading ties with neighbouring countries (SSHA, 2018). For decades the Grand-Nord has been under attack by foreign and local armed groups, such as the Allied Democratic Forces, Nduma Defence of Congo and Mai Mai militia groups (see Figure 2), and by a national military presence that is perceived as a foreign, occupying force. The population is often caught in violence between irregular armed groups and government forces engaged in counterinsurgency (Congo Research Group, 2018; SSHA, 2018).

The country was also in the midst of a political crisis, focused on preparing for presidential elections that were heavily contested in North Kivu, due to its historical sense of disenfranchisement. The cancellation of voting in the region in December 2018 further destabilised the response setting. Figure 3 illustrates the progressive rise of security incidents over the first months of the response, including their spike in the months following the election cancellation.

In addition, at the time of the 10th Ebola outbreak, the government and the HCT were 'overwhelmed' with a number of other crises in the country, including a Level 3 IDP response (expired end of May 2018) – all of which had received funding at a fraction of their appeal levels. The readiness or capacity of WHO's partner UN agencies, MONUSCO and INGOs to step up quickly and provide support in the areas of political analysis, security, logistics and complementary programming was limited. According to interviews with senior UN officials at headquarters and country level, EVD 10 was far down their list of priorities. With the humanitarian system overwhelmed (in DRC and globally), 'everyone was relieved that WHO was handling Ebola', according to one senior official. Coming off what appeared to be a neat conclusion to EVD 9, the outlook of the aid community in DRC at the onset of the outbreak (with some exceptions) was characterised by limited bandwidth to deal with a new crisis in the Grand-Nord, and wishful thinking that the outbreak could be quickly extinguished.

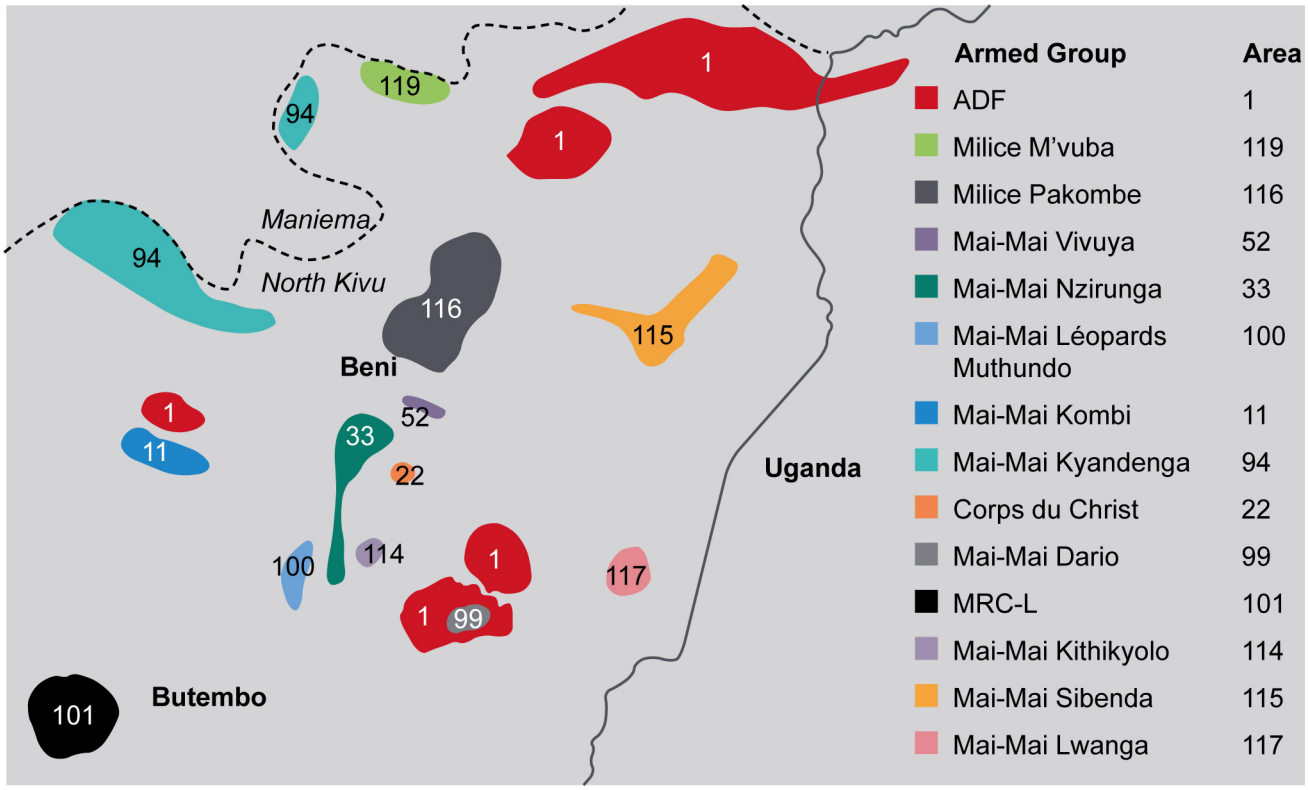
19 September 2018, 10,000 doses had been administered (WHO Regional Office for Africa, 2020). In November 2018, the MoH also began testing three cutting-edge therapeutic treatments in Ebola Treatment Centres (ETCs) in Beni, Katwa, Butembo and Mangina under the overall umbrella of WHO's Blueprint for Research and Development (ECDC, 2019; IOAC, 2019a).[5]

2.1.1 Context strains the effectiveness of the response

Despite these positive initial steps, the context of North Kivu quickly proved to be substantially more challenging than relatively stable and isolated Equateur, and the response model – untested to that point in a complex, humanitarian and urban setting – was severely strained. Hopes to rapidly contain and end the outbreak were quickly dashed as the disease spread geographically, with the government response playing 'catch-up, recruiting and training surveillance teams after new Ebola cases had been found' (Congo Research Group, 2020). In early August 2018, the response had identified 43 confirmed or probable cases, with most of them centred in, or originated from, Mangina (ECHO, 2018a). By mid-October there were 214 cases in 10 different health zones (ECHO, 2018b). As of December 2018, the number of cases had reached 549 in 15 health zones, with

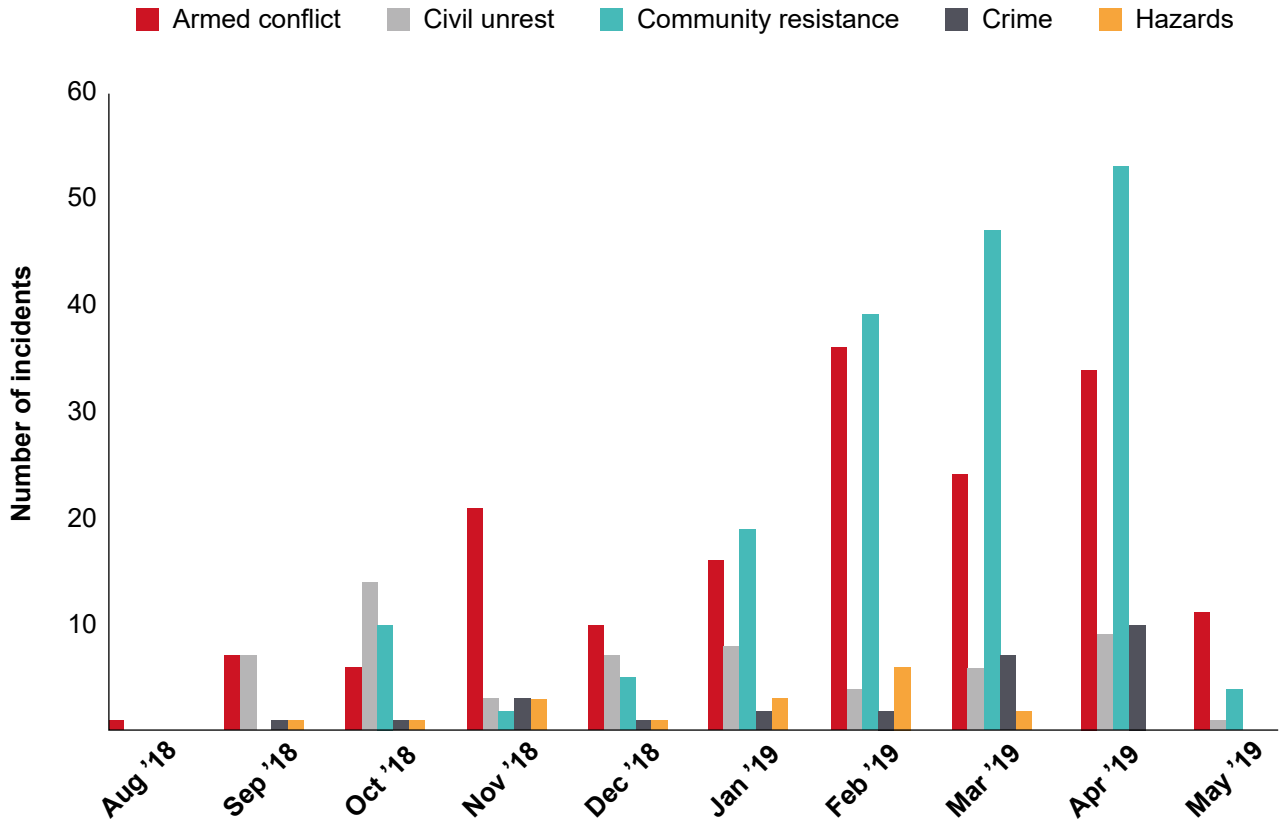
5 The rVSV-ZEBOV vaccine was also utilised during EVD 9 in Equateur. The three therapeutics utilised were culled from five therapeutics initially investigated based on their reported efficacy (Mulangu et al., 2019).

Figure 2: Armed groups around Beni territory, North Kivu



Source: adapted from Congo Research Group (2018)

Figure 3: Security incidents by type in the 10th Ebola outbreak, August 2018 to 5 May 2019



Note: Although this chart ends on 5 May 2019, that is not to say security incidents subsided. Insecurity Insight (2020) notes that, while the highest numbers of attacks against health care workers occurred between February and May 2019, numbers did stay elevated through November 2019.
Source: Ilunga Kalenga et al. (2019)

240 deaths (ECHO, 2018c; DRC MoH, 2018c).[6] The numbers of cases and deaths would continue to rise until mid-2019 when the total number of infections as of July reached 2,512, with 1,668 deaths (ECHO, 2019).

According to WHO, from 'the beginning of October 2018 it was starting to become apparent that the profound challenges posed by the operating context of North Kivu and Ituri were having an impact on the effectiveness of the response' (WHO, 2019: 12). The primary challenges were access to affected communities due to 'attacks on communities and the response by unidentified armed groups, and second, resistance to the response from communities themselves' (WHO, 2019: 12; see Box 1). In November 2018, both WHO and the United States Center for Disease Control (CDC) signalled that the outbreak was entrenched and would last at least six more months (Sun, 2018).

2.1.2 The response was slow to adapt

Despite recognition that the initial response model was ill-adapted to the security, health system and cultural challenges of the affected region, several more months would pass – with infections rising, armed groups more directly targeting response staff and structures and communities increasingly resistant to the response – before a fundamental re-assessment of strategy was considered. SRP2 (November 2018–January 2019) doubled down on the same model introduced under SRP1 and increased the footprint of response teams to cover 10 additional health zones. These teams, in turn, encountered or provoked armed attacks and community resistance in the newly affected health zones. Every serious security incident meant shutting down the response and 'giving the outbreak opportunity to spread under the radar' (WHO, 2019: 15).

Some senior officials with WHO and other UN agencies suggested that importing the response model and response teams from Equateur into North Kivu was based on a calculated risk, and that they were fully conscious of the contextual factors that would later prove so consequential for the spread and prolongation of the outbreak. The MoH and WHO were focused on the bio-medical argument that every day lost in isolating patients and contact tracing would spread the outbreak and prolong the response. This may have been influenced by some donor policies that focused primarily on health-related outcomes and placed less emphasis on complementary approaches – a phenomenon also documented in the West Africa outbreak (Lamoure and Juillard, 2020). The few actors that dissented early on from this 'go big, go fast' model and urged a more deliberate and consultative approach were either not welcome in formal planning discussions (the case of some INGOs) and/or dismissed as naïve or ignorant about the disease and intervention exigencies.

With the preparation of SRP3 (planned to cover February–July 2019), major international partners and donors had lost confidence in the response management and its ability to overcome security and community resistance constraints, despite greater emphasis in the document on a multi-sectoral approach to address other needs of the community beyond Ebola. In a joint letter sent to USAID (with the HC in copy) in late March 2019, OCHA, UNICEF and IFRC leadership called for greater emphasis on, and funding for, a 'community-based approach to improve community acceptance … with increased roles for civil society and for multi-sectoral humanitarian coordination support by UNOCHA'. Donors interviewed for this study also mentioned they were unconvinced by newly introduced frameworks for resource accountability and transparency, and had made it clear they were unwilling to continue funding the response without changes in the approach.

6 For comparison, EVD Outbreak 9 in Equateur province (17 May–24 July 2018) identified 54 total cases, with 33 deaths in a total of three health zones (WHO, 2018).

2.2 Phase 2: a 'final push', a multi-sectoral Strategic Response Plan and the UN 'scale-up'

Donor concern with the leadership and coordination of the response culminated in a joint letter, sent in late April 2019, from senior officials of the World Bank, US, UK, European Commission and Gavi to the UN Emergency Relief Coordinator (ERC) and the Director-General of WHO. In it, they expressed extreme concern 'about the severity of the outbreak and the downturn in both security and epidemiological trends in the last month' and called for the appointment of a senior official 'who is **fully and formally empowered to lead full time** the relationship with the DRC Government on Ebola and is able to give direction across the UN family including WHO, OCHA, UNICEF, IOM [International Organization for Migration] and WFP [World Food Programme] as well as other international stakeholders e.g. NGOs involved in the response' (emphasis in original).

In response to donor concerns, an increasingly out-of-control outbreak (2,512 cases and 1,668 deaths as of July 2019 (ECHO, 2019)) and the UN's own assessment of the situation, there was a formal and comprehensive reckoning – involving a broad coalition of national authorities, UN agencies, international and national NGOs and donors – of the shortcomings of the response to date and the continuing challenges facing responders (WHO, 2019). Billed as the last response plan, or 'final push', and commencing the second phase of the response, SRP4 called for a full-strength, maximum-capacity effort, in all sectors and sub-coordinations (DRC MoH, 2019b). For the first time, the SRP explicitly emphasised synergies between public health activities and those of the security, humanitarian, financial and operational readiness sectors. It was accompanied by major changes to the response's leadership structure for both the government and international partners.

The Secretary-General appointed David Gressly, who had been serving as the UN's Deputy Special Representative responsible for operations in MONUSCO, as Ebola Emergency Response Coordinator (EERC). In what WHO described as 'a new whole-of-UN leadership structure' (WHO, 2019), Gressly would co-chair the Ebola Emergency Response Team (EERT) alongside the Assistant Director-General of WHO for Regional Emergencies, Dr Ibrahima Socé Fall. Their aim was to increase the coordination of international support and coherence within the UN system and among partner organisations. This appointment divided the international response leadership between WHO, which continued to lead health operations and technical support activities to the government, and a broader UN-wide effort to strengthen political engagement, financial tracking, humanitarian coordination and preparedness/readiness planning for Goma and surrounding countries (Salaam-Blyther and Arieff, 2019).

The appointment of the EERC was followed shortly after by IASC initiating its Humanitarian System-Wide Scale-up Activation Protocol for the Control of Infectious Disease Events for an initial period of three months (eventually extended through 27 March 2020). The 'scale-up' is designed to activate system-wide capacities in support of an empowered leadership model for a crisis that is overwhelming the capacities of government and the UN to lead and coordinate (see Box 2).

Although the IASC scale-up protocols recommend coordination through the HC and HCT, this did not happen in the DRC. Instead, the EERT was put in charge of the UN scale-up strategy.[7] As discussed below, this resulted in parallel coordination systems that ran counter to the recommendations emerging from the West Africa response (DuBois et al., 2015). WHO and the government continued to lead the health-centred response, and the EERC/UN led international support around complementary activities. In conjunction with international moves to 'reset' leadership and coordination and to address the crisis through a more multi-sectoral approach, the government transferred

7 The co-leadership model was put in place before the IASC activation. Instead of the activation leading to coordination through the HC and HCT as per the protocols, the EERT leadership structure was established and charged with the UN scale-up strategy. IASC subsequently enacted its scale-up.

Box 2: The IASC Humanitarian System-Wide Scale-up Activation Protocol for the Control of Infectious Disease Events

The IASC Humanitarian System-Wide Scale-up Activation Protocol for the Control of Infectious Disease Events was developed in 2018, building on recommendations coming out of the West Africa Ebola outbreak response.

The scale-up for infectious disease events, like the humanitarian scale-up, is based on five criteria: scale, urgency, complexity, capacity and risk of failure to deliver assistance effectively and at scale to the affected population. The activation of the scale-up calls for:

- immediate establishment of an HCT (if not already active), with the RC re-hatted as an HC and a WHO Representative appointed as Deputy HC;
- deployment of supplies and logistics;
- establishment of subnational coordination mechanisms, including space for national and international NGOs and civil society; and
- deployment of surge capacity and establishment by WHO of a common Situation Report.

Within five days:

- a Senior Emergency HC should be appointed, assisted by a WHO Incident Manager;
- a Statement of Key Strategic Priorities should be developed;
- funding mechanisms should be established via the Central Emergency Response Fund (CERF) and Country-based Pooled Fund (CBPF); and
- a flash appeal should be launched.

Later steps include the completion of a rapid assessment within two weeks, full Strategic or Humanitarian Response Plan within three weeks, an Operational Peer Review within three to six months and an Inter-Agency Humanitarian Evaluation within 9–12 months.

Source: IASC (2019)

responsibility for its response from the MoH to the Office of the President, and an executive secretariat was created to facilitate cross-government decision-making and action. The government response from this point was led by Professor Jean-Jacques Muyembe, a world-renowned Ebola expert.

In retrospect, it is clear that a shift to a more deliberate, consultative and inclusive response approach – particularly with regard to local health structures and communities – was key to overcoming the outbreak, just as it was in previous outbreaks (Campbell and Miranda Morel, 2017; Lamoure and Juillard, 2020). The eventual move towards 'anchoring' the response within local health structures was an important step. There was a great deal of disagreement among interviewees for this study about who was responsible for this shift and when it occurred. The timing of the 'reset' in leadership roughly coincided with a marked change in the response approach. It is unclear, however, whether it was determinant in overcoming the outbreak or only reinforced and hastened positive trends already underway, such as the government and WHO's decision in March/April 2019 to decentralise the response fully to community levels. There was, however, consensus that communities – facilitated by community-based actors and LNGOs – eventually felt greater ownership of the response and responsibility for their own care, which was critical for ending the outbreak.

2.3 Phase 3: response returns to HCT model

In the final phase, articulated in SRP4.1 (January–June 2020), the operation began consolidating progress towards 'zero transmission' and an exit strategy aimed at strengthening the resilience of health systems in the three affected provinces (DRC MoH, 2020). This transition phase was justified based on a confirmed and significant downward trend in new infections, which had become apparent from early October 2019 (ECHO, 2020; see week 41 of 2019 in Figure 4).

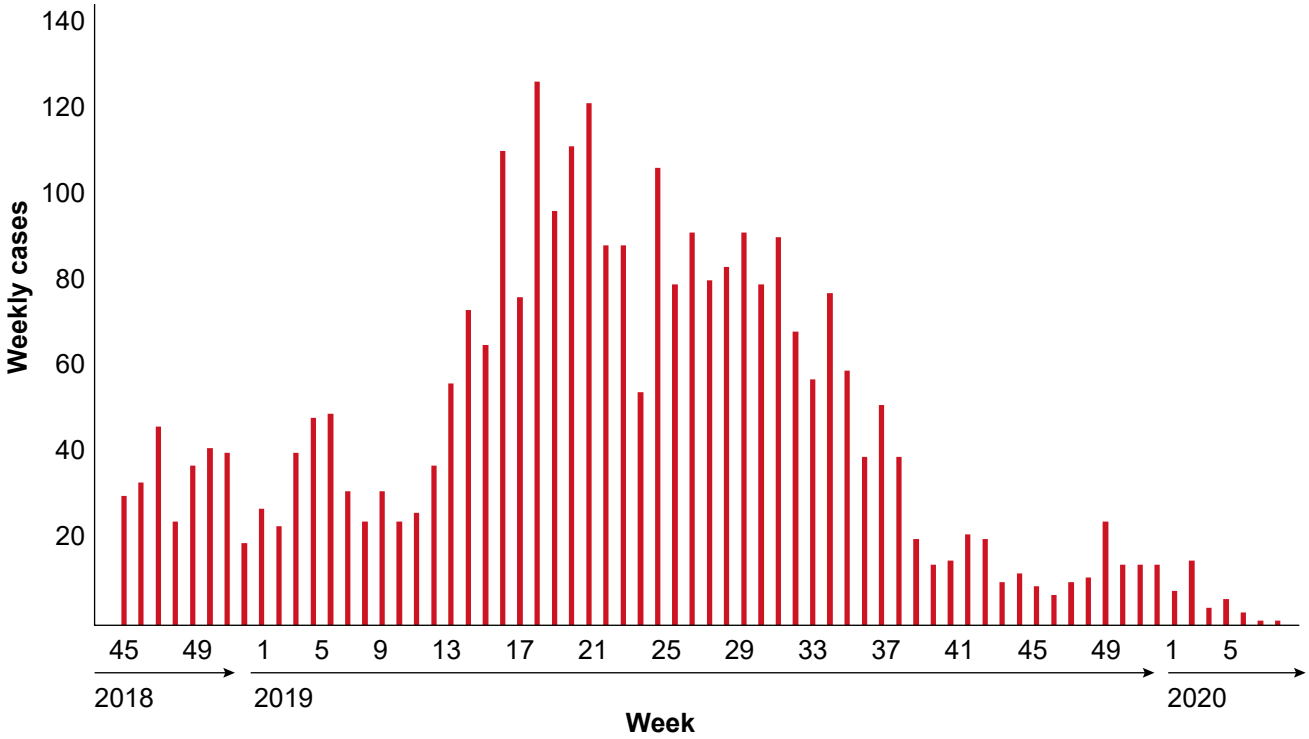
The EERT's role ended on 29 February 2020 and its responsibilities were transferred to the RC/HC (with the Deputy EERC still playing an active role until June 2020). A presentation by the EERT on 10 March noted that the outbreak was under control. Its four key messages highlighted the need for:

1. a multi-sectoral programme of 18–24 months in the three affected provinces;
2. a participatory and integrated process of identification and coordination with existing programmes from a sustainable development perspective;
3. a focus on meeting the needs and aspirations of communities; and
4. transparent and strengthened governance mechanisms down to the local level (EERT, 2020).

In April 2020, with the outbreak on the verge of being declared over, several new cases were confirmed; the official declaration of the end of the outbreak was delayed until June 2020.

As the response came to an end and the immediate threat of new infections faded, a new outbreak was declared in Equateur province (EVD 11) and the Covid-19 pandemic was declared. This meant the situation in eastern DRC was unable to sustain interest from donors. Local health officials and international health NGOs interviewed for the study noted concerns that EVD survivors and their families would not receive adequate medical and psychosocial care with the unwinding of international resource and coordination structures – especially given the risks of relapse within the first few years (see also Congo Research Group, 2020). They stated that North Kivu will be just as unprepared and ill-equipped to manage the next Ebola outbreak as it was with Outbreak 10, a concern echoed by several participants.

Figure 4: Weekly new cases of Ebola from November 2018



Source: ECHO (2020)

3 International leadership and coordination

On the international side, Phase 1 of the response (SRP1–3) was led by WHO (in coordination with the Government of DRC and MoH as leader of the overall response). During Phase 2 (SRP4), with the appointment by the UN Secretary-General of an EERC in May 2019, international leadership shifted to a joint model with the EERC and WHO sharing responsibilities. Phase 2 also saw the IASC activate the scale-up and the Government of DRC shift management of the response from the MoH to the Office of the President. Other actors within the leadership and coordination space included the World Bank and bilateral donors. This section examines the effectiveness – both real and perceived – of the leadership and coordination efforts of these actors as well as the underlying drivers of success and failure throughout the response, with a particular focus on the first two phases.

Overall, in both phases, international leadership was slow to organise an inclusive and coordinated response among the range of international actors – WHO, UN agencies, MONUSCO, INGOs, IFRC, donors and the World Bank – who would eventually contribute to collective efforts to overcome the outbreak. Gradually, international leadership and coordination structures adapted to emerging challenges and moved towards greater inclusiveness, improved information management and communication, and a harmonisation of purpose among responders. The more formal adjustments in leadership and coordination structures – i.e. the appointment of the EERC, strengthening of WHO leadership under Assistant Director General Socé Fall, the IASC scale-up and the change in government leadership – helped encourage these positive changes, but were not the key drivers of them.

3.1 The World Health Organization

WHO's key strengths centre on speed and technical expertise. When the 10th outbreak was declared, WHO jumped into action, airlifting equipment, personnel and the basic response strategy – supported by sufficient donor resources – from the Equateur response. Their operational and logistical capabilities at the outset of Outbreak 10 – as well as the speed and efficiency of introducing experimental vaccines and therapeutic treatments – have been widely praised from outside experts and partners on the ground (Salaam-Blyther and Arieff, 2019; IASC, 2020). This early and comprehensive action in DRC demonstrated a notable improvement on their performance in the 2014–2016 West Africa Ebola outbreak. WHO was able to meet, and often exceed, its target timeframes for each performance standard within the agency's Emergency Response Framework: labs were running within 24 hours, information campaigns were immediate and WHO's IMS and staff surge were quickly activated (IOAC, 2019a).

3.1.1 WHO's system and culture discouraged collaboration

These early successes, however, were in some ways overshadowed by other characteristics of WHO's leadership. In the early months of the response, many interviewees perceived WHO's leadership as dismissive of dissenting or cautionary views on the response strategy and disinclined to build or coordinate an inclusive structure of international partners. While some individual WHO staff members were praised by counterparts for their dedication and collaborative spirit, the agency as a whole fared badly on the leadership front

– leaving a trail of rancour. Senior response staff from UN agencies, donors and NGOs characterised WHO counterparts as deaf to criticism, 'insular', 'hubristic' and preoccupied with 'being in charge of everything'. Others described WHO leadership as being 'bruised' and 'embattled' from its experience in the West Africa outbreak and fixated on maximum visibility – on proving by 'going it alone' that its organisational reforms after 2015 were successful. Local officials frequently described MoH and WHO leadership as hand-in-hand, with both displaying condescending behaviour and ignorance of the context.

Although this comportment from WHO did not encourage a collaborative atmosphere, other international actors in country were reluctant to be drawn into a crisis they hoped would be rapidly managed by the government and WHO (see section 5.3). Some of these potential partners also had limited experience in working on a fast-paced disease control response. In practice, this combination of WHO's leadership posture and the fact that there were other political and humanitarian priorities in DRC meant that important UN and partner assets in DRC – particularly the HCT, MONUSCO and even OCHA – were not employed or sufficiently strengthened in a timely way to complement the MoH–WHO-led public health response.[8]

Regrettably, WHO's 'go-it-alone' attitude, combined with other international actors' insufficient expertise and reluctant commitment, persisted even as the severity and duration of the outbreak became apparent. One year into the response, WHO's Independent Oversight and Advisory Committee (IOAC) commented on 'a lack of involvement on the part of the broader humanitarian systems', concluding there is 'a fundamental problem with the way the UN humanitarian system and WHO interact during health emergencies' (IOAC, 2019a: 5, 7). The IOAC further pointed to the 'need to decouple decisions on when to transition from a health-focused response to a broader health–humanitarian response, and when to appoint empowered whole-of-UN leadership, from internal and external political pressures' (IOAC, 2019a: 41).

A number of donors and agencies involved in the response had hoped that a single and unified leadership structure would bring more cohesive international support to the response. Instead, in the view of these officials, WHO, as the de-facto UN and international leader in this public health crisis, was slow to correct or adjust its leadership at the country level, did not actively seek a greater UN-wide leadership model to confront the deteriorating situation (through, for example, advocating earlier within the IASC for a scale-up) and weakened the UN-mandated Ebola Emergency Response Office (EERO) structure by insisting on a joint leadership model (see sub-section 3.2.2).

At the most basic level of agency leadership in DRC, WHO was deficient. There was no permanent WHO Representative to DRC in post at the time of the outbreak, and the job remained vacant throughout the 22-month response (IOAC, 2019b; IASC, 2020) – despite a clear recommendation from the West Africa Ebola outbreak that the 'highest level of capacity must be ensured for the most vulnerable countries' (WHO, 2015: 7). WHO's IMS – reformed following the West Africa outbreak – assumed the country leadership for the response and, as designed, provided 'a structure that defines lines of authority as well as operational processes and activities required during an emergency or outbreak' (Ravelo, 2017: n.p.). The IMS was led by experienced WHO staff drawn from the region and from WHO headquarters. It was complemented by frequent visits of senior WHO leadership, including the WHO Director-General, which aimed to assess the state of the response and resolve problems through on-the-ground dialogue with operational staff and with high-level government officials. In March 2019, WHO appointed a senior official at the Assistant Director General level, Dr. Socé Fall, to lead the public health response. WHO also appointed a senior official on a temporary basis in Kinshasa to help liaise with government and partners.

8 See sub-section 3.2.1 for a description of how UN-wide structures worked together to a limited extent early in the response.

Missing in the IMS model, however, was a track record of pre-existing partnerships and relationships with agencies in the country or specific dedicated capacity to nurture and coordinate new partnerships. Since 2018, the health cluster coordinator position had been filled by WHO only on an interim basis (IOAC, 2019b). In interviews for this case study, UN agency partners and INGO staff complained about WHO's lack of outreach and communication, while WHO response staff often described frustration with the unwieldy coordination mechanisms and operational practices of their humanitarian counterparts (for more, see section 3.2). In their eyes, humanitarian actors operated through a time-consuming, horizontal, collective action model that focused on activities of marginal relevance to the disease rather than through a measurable, vertical, command and control system.

More generally, senior UN managers from a range of agencies at country and headquarter levels pointed to WHO as lacking the culture of partnership or collaboration necessary for the lead agency of a complex, multi-sector response that required teamwork beyond the health sector. According to them, this was reflected in an inability to interact constructively with humanitarian partners in DRC throughout the EVD 10 response. As leader on the health pillar of the response, WHO was generally appreciated for its technical expertise, but its reluctance to listen to, or consider, alternative technical viewpoints was also keenly felt by staff of medical INGOs with substantial experience of Ebola and other public health emergencies. Many partner-agency staff, INGO staff and donor experts described the government–WHO response strategy as doctrinaire and rigid, overly focused on a 'bio-medical' model rather than pursuing a more holistic community public health vision to tackle the outbreak (see section 5.1). WHO was frequently cited by experts interviewed as intent on eradicating the disease, or pursuing 'global health security'.[9] According to Social Science in Humanitarian Action (SSHA), community feedback reflected 'strong concerns about the consequences of Ebola on resurgent numbers of malaria, measles and cholera cases, which citizens felt were being neglected at the expense of Ebola' (SSHA, 2019b: 6; see also Congo Research Group, 2020).

WHO and UNICEF did work on specific interventions for malaria and measles during Outbreak 10. However, these efforts were considered insufficient in the face of surmounting need – including a country-wide measles epidemic in 2019 – while Ebola received disproportionate attention (Arie, 2019; WHO Regional Office for Africa, 2019). In addition, from SRP1, free health care was provided in affected areas via the World Bank-funded Health System Development Programme (PDSS) (DRC MoH, 2018a).

Several WHO staff and advisors noted the lack of a robust 'challenge' function or culture within the agency that could provide space to question orthodoxy (or inertia) on ongoing operations and encourage real-time adaptations. One senior staff member noted that the fast WHO scale-up had been achieved through deploying consultants and less experienced staff who were managing without a 'proper supervisory structure' that could have helped to correct any problematic decisions taken. Another senior WHO advisor pointed to an insularity at WHO headquarters in Geneva that allowed discrepancies between discourse (e.g. on the theory of the EVD response model being employed) and field-based realities to persist longer than they should have.

More specifically, practitioners interviewed citied insufficient skills and capacity for information and financial management. The health cluster, chaired by WHO, was not utilised to help coordinate response efforts in North Kivu (IOAC, 2019a). This hindered potential health partners in the region from

9 The 'health security' approach in DRC, according to medical experts interviewed for this study, focused on identifying and isolating cases rather than on the broader 'public health' impacts of the outbreak and the response on the population's health (e.g. lack of engagement and partnership with the population, cessation of many non-Ebola preventative and curative services, actions that alienated the response from the population). The origins of this approach can be traced back to the designation in 2014 of Ebola as a 'global security threat' and a preoccupation with preventing the 'spread of the disease to the Global North' (Congo Research Group, 2020: 8).

being well-informed and possibly contributing to the response; or it required them to join parallel coordination efforts (the Ebola-specific MoH–WHO coordination structure and later the EERO coordination structure) to stay informed and understand whether their contribution might be able to fill gaps. More broadly, numerous interviewees described the MoH–WHO coordination structure as unwieldy and poorly managed. Many pointed to poor information-sharing between the various pillars of the response; poor communication flow between national, provincial and local coordination structures; inefficient meeting management; insufficient mapping of interventions and gaps; and little transparency on resources. Several interviewees felt that the constraints faced by WHO on information and financial management highlighted the limited presence of OCHA to support in these areas. Senior UN officials interviewed for the study attributed this to a reluctance on the part of WHO to accept or invite greater OCHA support – in part to avoid the risk of muddying roles and responsibilities and in part motivated by a desire to demonstrate that WHO could successfully handle the outbreak on its own. OCHA, for its part, was reluctant under these circumstances to try and impose a more forceful presence.

3.1.2 Threats posed by context were under-appreciated

According to WHO staff and other experts interviewed, there was a basic understanding from the outset of how different the context of Outbreak 10 was from previous outbreaks in DRC, and how this could impact the response. The density of the population, its mobility (including to other provinces and across borders with Uganda and Rwanda) and the prevalence of armed conflict and risks of attack are all cited in SRP1. Nevertheless, the response leadership did not take its own admonition to 'show considerable patience, as the situation in the region is very unstable' (DRC MoH, 2018a: 7), and take the time needed to more fully understand the depth of threats that might be unleashed by a large and externally driven response. In good faith and with sound epidemiological arguments – which called for speed, not patience – the government and WHO believed (or hoped) they could isolate and extinguish the outbreak as they had for previous outbreaks.

The response came tantalisingly close to containing the virus during the outbreak's early weeks – and if it had been contained in those days the performance of the government and WHO in the 10th outbreak would have been praised. As the Congo Research Group reports, 'initially, the management of the tenth epidemic might have seemed to be off to a good start. Many experts had been flown in, and the cases seemed confined to Mangina. … In the community, things were proceeding as they had in prior epidemics' (Congo Research Group, 2020: 14). In retrospect, however, it is clear that there was a fundamental under-appreciation of just how risky the context was, even with the availability of new drugs and vaccines. Some donors and NGOs emphasised in interviews that they pushed hard early on to raise awareness around the complexity of the context and to advocated for changes in the response approach, but the government and WHO were unresponsive. This certainty on the part of WHO – that it could manage international efforts in support of quelling the outbreak on its own, importing a response plan into the very different setting of North Kivu, working with a contested national government – was described by numerous staff from partner UN agencies, local authorities, local and international NGOs and other experts as 'arrogant' or an 'act of hubris'.

At the heart of the poor context analysis was a lack of sensitivity to the depth of hostility in the Grand-Nord of North Kivu for the central government and its representatives, with whom WHO worked closely. The population's scepticism for authority and distrust of officialdom fairly quickly manifested itself in resistance to the top-down, fear-based public health messaging employed by Ebola response teams at the source of the outbreak in Mangina (Kemp, 2020). Indeed, this did more harm than good: as Congo Research Group (2020: 14) notes, 'Driven by fear and mistrust of the Response, many left Mangina, dispersing Ebola across the region'. With the disease spreading through the region and into urban areas, the footprint of 'foreign' response

teams (including armed escorts and MoH staff from Kinshasa who had displaced local health staff) increased. Meanwhile, the population's historical tendency to distrust central authority – fuelled by rumours, a perception that the response size was disproportionate to the threat, and by contradictory and unclear messaging on the disease itself – helped cement, in the early weeks of the response, a problematic 'response–community' dynamic, which would prove difficult to re-calibrate.

Another major contextual factor that appears to have been under-appreciated within the 'no regrets' response deployed by WHO and others was the risk of corruption and the distortionary effects of large expenditures in a heavily armed, politically contested conflict zone. These risks are hardly new in DRC and have been well documented over the past three decades. A recent review of operational exposure to corrupt practices in DRC mentions 'the entrenchment of systems of predation that operate in every sector in the DRC, including humanitarian aid' (Henze et al., 2020: 1). The review points specifically to corruption pressures 'exerted by local authorities, armed groups, host community members and/or staff of aid organizations' (ibid.: 2). In the case of humanitarian aid, the review 'finds a clear correlation between the risks of corruption and the time taken to deliver humanitarian assistance' (ibid.: 3).

The emphasis on quick delivery of assistance, unsurprisingly, made carrying out necessary due diligence and installing effective anti-fraud mechanisms difficult (ibid.). While the EVD response was managed primarily by public health actors, such as WHO and the MoH, rather than humanitarian actors, the consequences of spending in '"captive markets" in which price negotiation [was] virtually absent with the excuse of the need for fast operationality' should have been predictable: there were 'significant tensions about who can benefit from the resources … [and] the development of illicit economies' (ibid.: 12). Correcting or controlling the corrosive effects of spending decisions taken without due diligence and without effective control mechanisms is another theme that dominated the management of the response as the outbreak progressed (see also sections 4.3 and 4.4).

3.2 The UN system

The key strength of the UN system in the 10th outbreak was its ability to bring together many different kinds of actors – particularly humanitarian and peacebuilding – who had contextual knowledge of the Grand-Nord and experience managing operations in complex emergency settings. The UN system as a whole, however, was slow (and reluctant, as discussed above) to commit its collective strengths in support of the MoH–WHO-led response. The UN's deference to WHO's leadership of the international response – as seen in the actions of the UN Country Team and MONUSCO at the outset of the outbreak – quickly became untenable, especially as the security situation was severely deteriorating, failures around community engagement were evident and the corrosive effects of 'Ebola business' were growing. Despite this, the Special Representative of the Secretary-General (SRSG) in the DRC and the RC/HC did not appear to be working actively to introduce a more integrated response model. Likewise, OCHA, the ERC and the UN Secretary-General did not actively challenge the primacy of WHO in the international response at an early enough stage. This hesitancy to forcefully advocate earlier for a scaled-up UN-wide approach delayed implementing an integrated response.

According to interviewees, UN agency and INGO staff urged WHO to adopt – and to encourage the government to adopt – a more holistic, conflict-sensitive approach, rather than an Ebola-specific approach. They were gradually able to contribute to this with the establishment of the EERT and the activation of the IASC scale-up, which signalled a concerted effort to move in this direction. For international response staff, especially INGO staff, the appointment of Gressly ushered in a period of greater inclusivity in which they were welcomed at coordination meetings and their views and expertise were appreciated. The elaboration of SRP4 and its greater emphasis on a multi-sectoral approach opened up space for a wider range of actors (see Box 3) and unlocked funding channels that had previously been more concentrated on core public health response actors. Experts from medically focused NGOs reported a shift to a more collaborative, creative

Box 3: SRP4's multi-sectoral approach (Pillar 3)

Pillar 3 of SRP4 – 'Strengthened support to communities affected by Ebola' – was specifically developed to address broader humanitarian needs, including broader health needs. It was led by the EERC with support on community works from the World Bank via the Social Fund of the DRC (FSRDC), community ownership and essential services from UNICEF and enhanced coordination within the broader humanitarian response from OCHA (UN, 2019). The pillar was well funded (roughly $98 million allocated out of the $100 million requested, according to internal World Bank finance-tracking documents), with $23 million allocated to labour-intensive works and $75 million to community engagement and basic services. The study team, though, found little concrete, consolidated evidence of what was accomplished under Pillar 3. Unlike Pillar 1 of SRP4 (Public Health), which had a relatively sophisticated monitoring system based on key performance indicators (Bruni et al., 2020), Pillar 3 seems to have received less attention as far as tracking results. Although the idea behind a broader humanitarian pillar was sound, international actors felt that it was slow to get started and unevenly executed. Local actors, by contrast, felt Pillar 3 improved coordination between humanitarian actors and increased emphasis on community engagement (see section 4.1). According to one LNGO worker, 'Pillar 3 brought the humanitarian organisations and the Ebola response closer together'.

and flexible approach to tackling the outbreak. LNGOs, community-based organisations and local leaders and health officials noted that SRP4 allowed them to participate in the response more meaningfully, having been largely excluded before mid-2019. Much of this change was also attributed by interviewees, and particularly by local interviewees, to the leadership style and expertise of Professor Muyembe and his newly appointed Incident Manager on the government side, as well as renewed engagement with OCHA and UNICEF. Other changes that came with establishment of the EERT – such as a greater focus on community, a partial shift to a 'security by acceptance' rather than a 'security by protection' approach and attempts to curtail inflated payments and introduce more financial transparency – took time to be realised. These changes are examined in detail in chapter 4.

3.2.1 UN in-country leadership and agencies lagged behind the crisis

Early involvement of the in-country UN leadership was influenced, as previously mentioned, by limited capacity and the demanding needs of other crises in the country. In practice, this meant the HCT was relieved to let WHO take the lead in supporting the government in the early months of the EVD crisis, in the hope it would be over quickly. That said, during the early weeks of the response, the HCT collaborated with and provided effective support to the government–WHO leadership. The Deputy HC was designated to lead UN and HCT support to the response in Beni, where the initial national coordination structures were established. According to early responders, a tight-knit and collegial coordination led by the Deputy HC, together with the WHO and government Incident Managers, was able to manage the prioritisation of daily interventions, facilitate communication between government and international actors and strategise on security management.

This support from the UN, however, was not reinforced systematically as the outbreak spread to numerous health zones. OCHA offices in the affected region, for example, were not reinforced to provide coordination assistance to the Ebola response, even as government–WHO Ebola coordination structures multiplied across different health zones. UN support on security continued to be erratic, diffused across security officers deployed by various agencies and the UN Department for Safety and Security (UNDSS). According to WHO and other staff interviewed, the UN system utterly failed to establish a comprehensive security strategy for the response. UNICEF, which led the RCCE pillar, critical for engaging affected people, was unable to recruit enough staff until mid-2019, almost a year into the response. The United Nations Population Fund (UNFPA), which led the country-wide PSEA mechanism, was unable to replicate this work convincingly within the response. Recent reporting has highlighted the scale of abuse in the EVD 10 response and the

ineffectiveness of any PSEA efforts (Flummerfelt and Peyton, 2020; see section 4.4).

A blow to effective early coordination, according to WHO and other UN agency staff involved, was the government's decision in February 2019 to move the national coordination structure to Goma. According to these interviewees, the move unravelled a functioning, if increasingly overstretched, coordination structure that was close to affected areas, and transported it to a setting that was distant (an extra plane ride would be required to reach any affected areas), unwieldly (Goma has served for decades as the staging point for dozens of international agencies working in eastern DRC on non-Ebola programmes) and politically fraught (creating a further layer of government bureaucrats between affected health zones and decision-makers in Kinshasa). One motivation for this move was pressure from donors whose security policies did not allow their staff regular or easy access to Beni, Butembo and other areas of the Grand-Nord most affected by the outbreak (the US in particular, though UK staff also had travel restrictions). Other response staff, however, argued that the move to Goma was also motivated by other considerations: it allowed field-based teams to operate freer from political interference; it brought a wider universe of humanitarian actors into the response; and it brought needed attention to Ebola preparedness within Goma city itself.

3.2.2 Dual leadership EERT created confusion and diffused accountability

According to agency, NGO and donor staff interviewees, the joint leadership model of the EERT brought a welcome expansion to the Ebola response – in the form of additional complementary actors and interventions – but it reinforced compartmentalised and parallel coordination structures. For most staff on the ground, the role and responsibilities of the EERC were unclear, and the delays in staffing the office contributed to this lack of clarity. Rather than a single cohesive leadership and coordination structure, the UN Secretary-General – on the advice of the ERC and the Director-General of WHO – opted for a structure (the EERT) that created two distinct decision-making and coordination bodies. In Goma, according to interviewees, this was reflected in a comical situation where the government- and WHO-led coordination met in one venue (led by the government, with meetings held in French) while a parallel coordination structure (led by the EERC, attended by international actors and with meetings held in English) met at a second venue. This split also had implications for operational efficiency, for example delaying the deployment of more integrated rapid response teams, which required the government to seek support from two separate UN entities: WHO (with whom it had ongoing procedures on health-focused interventions) and EERO (on whom it needed to rely for some of the response's complementary interventions).

Lessons learned from West Africa called for the creation of a 'single, unified' governance structure headed by 'a strong leader … [with] a finely honed sense of how to coordinate with many other partners and actors' (WHO, 2015: 16). Instead, the process of reaching agreement between the WHO team and the EERT (both UN entities) on how international leadership and coordination would function in support of SRP4 was, as described by a senior UN staff member deployed to help launch the EERT, akin to 'negotiating a peace treaty … we had 17 versions (of the draft) and every word was counted and debated'.

The appointment of dual coordinators for the response may have reflected a necessary compromise within the UN – where the Secretary-General has limited authority over UN funds and programmes and especially over specialised agencies, such as WHO. However, this leadership model as experienced in DRC was widely criticised by agency response staff, donors and government officials who were looking for a single, authoritative leader that could act unilaterally and decisively across the whole spectrum of the response. One senior government response official bemoaned the experience, noting 'the UN was tearing itself apart in front of us'.

The UN, with its semi-autonomous component parts, often has real challenges in complex settings to field a hierarchical incident manager-

style structure, with a single person responsible for the overall UN response. Instead it must rely on consensus and collaboration. This makes understanding where overall accountability rests within the UN system difficult. In this outbreak, WHO was accountable for bringing Ebola infections to zero, but there was a collective and diffused accountability within the UN system for almost every other aspect of the operation, from delays in scaling up meaningful community engagement interventions, to ensuring minimum standards on 'do no harm' and humanitarian principles, to implementing good-practice security and financial measures, to the eventual impacts of these shortcomings on affected communities (see chapter 4).[10]

3.2.3 IASC scale-up was triggered late with modified protocols

Although designed to bring predictability and order to system-wide mobilisation, the scale-up, in its first test, showed the limits of applying standard operating procedures in a politically complex and fast-moving crisis. The ERC activated the scale-up several months after it became apparent that a more integrated response to contain the virus was needed and only after a special coordinator was appointed. Senior IASC agency staff interviewed, as well as reviews of the response, stressed that the absence of context-based triggers in the protocol – formal or informal – for considering its activation contributed to a collective delay in reassessing leadership and coordination structures (IOAC, 2019a; IASC, 2020). These might be based around context (urban versus rural or population density), ongoing humanitarian needs and priorities of at-risk people or on the actual numbers of infections or deaths. But an effective and adaptable scale-up protocol needs to rely not just on triggers or algorithms, but also on organisational cultures that value partnerships, and on individuals with leadership skills who build consensus. This was not always evident in this response. Indeed, the intervention of donors, rather than structured reflection on the part of the UN or IASC, appears to have driven the scale-up decision.

The scale-up was also not implemented in other ways according to its provisions (see Box 2; IASC, 2019). Humanitarian clusters in support of the response, coordinated by OCHA, were never activated. The protocol's provision that WHO play a supporting role – through the Deputy HC and supporting Incident Manager role – was also modified. Instead a separate coordination structure was built around the EERO, with Gressly as EERC appointed to co-lead with Socé Fall of WHO. Indeed, despite what the activation protocol implies, UN senior management (the ERC or even the Secretary-General) has limited authority to impose a strengthened leadership/accountability structure on any response – especially when a UN specialised agency is reluctant to cede control or authority – and therefore must seek a consensual model (even if WHO had previously endorsed the protocol on paper). In addition, scale-up by the IASC itself does not apply to other important actors in a crisis response including, in the case of Outbreak 10 in DRC, the government, MONUSCO and the World Bank. The resulting scale-up, with its dual leadership (and its tortured negotiation at field level on respective roles and responsibilities), reflected these realities in DRC.

Finally, the protocol also prescribes an Operational Peer Review to be undertaken within three to six months of the scale-up and an Inter-Agency Humanitarian Evaluation within nine to 12 months (IASC, 2019). Neither of these were completed as recommended, and two structured opportunities for reflection and course correction while the response was still underway were missed. An Operational Peer Review was finally undertaken eight months after the scale-up, in January 2020, too late for any adjustments to have impact as the outbreak was already under control. In addition, a proposal by the EERO for a real-time evaluation in mid-2019 – with funding secured from the World Bank – was never agreed upon by the response leadership.

10 This diffused accountability is illustrated by the contrast between performance and outcome indicators for key public health interventions to bring Ebola infections to zero (developed and monitored by WHO) and a lack of reporting on performance indicators for Pillars 2 and 3 of the EERT (IASC, 2020).

3.3 The World Bank and bilateral donors

3.3.1 World Bank 'no regrets' funding brings pros and cons

The role of the World Bank was at once outsized and confusing in the view of implementing agencies and bilateral donors. Because the Bank has not historically been a large actor in many humanitarian settings, this further confused their ways of working. For some humanitarians interviewed, it was unclear whether the Bank was trying to learn and adapt to operating in a crisis setting, or if it was simply continuing with its traditional country operations and modes of working.

As a major donor to the response (see section 4.3), the Bank worked closely with other donors on joint messaging, information-sharing and ensuring that resource gaps were identified and filled. At the same time, World Bank money was financing – through its lending and grant operations with the MoH (and via the MoH to WHO, UNICEF and other agencies) – practices and policies in the response, such as government pay scales for service providers, that the Bank's donor partners (and some Bank staff) felt were wasteful, corrupt and contributing to the deterioration of the security situation and the prolongation of the outbreak (see sections 4.3 and 4.4). It should be noted, however, that pay scales for health staff were set by the government and used by all partners, not just the World Bank. Overall donor and agency spending levels in the response – not just those financed by the World Bank or specifically the spending that went to local salaries – contributed to a widespread perception of waste and corruption. According to the World Bank, 60% of the budget for the Ebola response went to the payment of international salaries.

Despite the concerns of some bilateral donors about government corruption and capacity and their own unwillingness to channel resources through the government, these donors were also supportive of the Bank using its multilateral funds – which by definition pass through the government – for the overall response.[11]

According to Bank officials, donors and other response agencies, the Bank had direct and frequent contact with the Minister of Health and other MoH officials leading the government response and played an informal role in ferrying information and concerns between international partners and the government. One of these roles, according to Bank officials, was helping the MoH to identify and correct poor administrative and financial management among the UN agencies who were recipients of Bank resources. In the spring of 2019, the Bank joined other donors in calling for a major overhaul/reset of leadership for the response, which led to the appointment of the EERC – an overhaul that was resisted both by its main government counterpart (MoH) and some Bank staff involved in the operation who saw it as counterproductive to the institution's *raison d'être* of supporting and reinforcing government-led responses. Under SRP4, Bank financing expanded to other implementing partners, such as staff in the EERO – even as it was also charged under SRP4 with providing unbiased and transparent financial management for the overall response. Finally, the Bank was also funding complementary implementation activities, such as priority rehabilitation works in Ebola-affected communities, through its project in support of the FSRDC.

These various roles of the World Bank were not well understood by partner international agencies and other donors. Humanitarian actors, in particular, were troubled by the absence of neutrality in the Bank channelling resources through the government in a conflict setting (a modality nevertheless fully consistent with its mandate and regulations). With the World Bank

11 There is some dissonance in describing the World Bank as an independent donor that is separate from the major bilateral donors who have a large role in financing and shaping Bank policies and actions. In practice, though, as in the EVD 10 response, the Bank can at once be capitalised globally by the very donors who at the country and operational level in DRC – especially among their humanitarian staff – questioned whether the Bank's mandate of working through the government was appropriate in a complex emergency setting. Donors who refused to channel their bilateral resources to the response through the government, because of corruption and capacity concerns or because of risks to humanitarian principles, appeared largely to turn a blind eye to their multilateral contributions to the Bank being used in exactly this way.

providing almost all of MoH's resources for the operation, some humanitarian donors felt they had little leverage to coordinate messaging and push for approaches that would be consistent with humanitarian values since the government was not reliant on them for financial support. Senior international staff interviewed for this study raised concerns about what they perceived as the Bank's complacency or naiveté in operating in a setting well known for corruption. One senior official, acknowledging the pressure felt by the Bank to make available its cash for the 'no regrets' international response, also remarked that the Bank put too much trust in the MoH and suggested that a typical Bank project with similar suspicions around expenditures and transparency would have been immediately suspended. Several more indicated that at least some leadership and coordination responsibilities – and accountability – in an emergency response (or a public health response in a conflict setting) naturally resides with those holding the purse strings, especially if a multilateral institution sits in that position. For these officials, the World Bank could have played a greater leadership role with more transparency, as opposed to its behind-the-scenes facilitation. Bank staff, on the other hand, argue that a leadership, coordination or convening position is inherently a political role and would be inconsistent with the ban on political interference established in the Bank's Articles of Agreement.

3.3.2 Bilateral donors worked effectively to reshape the response

From early in the operation, major donors played a coordinated role in challenging the effectiveness of response leadership structures and in providing a steady drumbeat of scepticism about the response strategy being pursued. This was facilitated by the deployment of donor representatives to the field (generally a good practice, as cited by a range of interviewees) and, eventually, strong coordination and information-sharing among key donors – notably the US, UK, European Commission and World Bank. From the beginning of the response, donors were represented in coordination structures, first in Beni and later in Goma.

From the perspective of implementers in the field, however, the role of donors and their understanding of the nuances of the operation were mixed. Those donors whose staff were deployed close to field operations or working embedded within the government response (e.g. the European Centre for Disease Prevention and Control (ECDC), or CDC) or for greater periods of time (e.g. European Commission) were more appreciated, as they were seen as promoting constructive dialogue within coordination structures. The rapid turnover of some donor staff (e.g. US), sometimes based on six-week deployments, and their posting in Goma away from operational areas (e.g. UK) was viewed as less conducive to building useful relations with government leadership and coordination mechanisms, especially when those deployed did not speak French.

4 Key challenges to an Ebola response in a complex, conflict setting

Leadership and coordination mechanisms had a profoundly negative impact on outcomes related to community engagement and acceptance, security approaches and sound financial management. Although some lessons were learned from previous outbreaks, the challenge presented by the context of EVD 10 exacerbated many issues that had been present in previous responses. Nor is it easy to disentangle the impacts of strategies pursued around community engagement, security and financial resourcing from one another. The security situation necessitated the use of protective forces in some cases, but they were employed excessively, in the view of communities, including in areas of lower risk. This was at odds with communities' preferences, causing fear and apprehension that contributed to community resistance towards the response. High payments to protective forces and to service providers (including community members) shaped an Ebola economy that created perverse incentives to maintain the insecurity of the area and prolong the outbreak in other ways. While many of the decisions around community engagement, security and financial management were made based on hopeful thinking that the outbreak could be defeated quickly, early decisions set the tone throughout the response. Many of the corrections undertaken from November 2018 until the end of the response sought to undo the damage of those first three months.

4.1 Community resistance, engagement and acceptance

Community resistance – often expressed through either a deliberate refusal to follow medical guidelines or an active rejection of, and acts of violence towards, the response – had several root causes. Many interviewees – including some WHO and government staff – attribute failures around community acceptance to decisions made early on by response leadership and coordination structures, such as not adequately resourcing the RCCE pillar of the response, while underappreciating the political economy of the affected areas. Although these conclusions have some validity, the causes of persistent resistance to the response were complicated. Even an ideal effort at promoting community acceptance would likely have met significant opposition given the context of the Grand-Nord. The area had not encountered Ebola previously, and many suspected it was being spread purposely as a genocidal attack against the Nande. Others believed that the outbreak was fabricated in an attempt to disenfranchise millions from the national elections, scheduled for December 2018. These rumours were fuelled by politicians and others who exploited the outbreak for political or financial gains (SSHA, 2019b). The prevalence of armed actors and history of violence meant that misinformation and manipulation could quickly become threats and real violence directed towards response teams.

The management of the response also caused community resistance. The push for speed meant that taking time to engage communities

and ensure their participation in designing and implementing response activities was seen as a luxury that could not be afforded. Communities resisted medical treatments and preventive measures because they did not understand why they and their families were taken to ETCs. Some elements of the response were also perceived as insensitive. For instance, ETCs made from plastic sheeting made people feel like refugees rather than part of a stable permanent population, and when Ebola teams came without explanation to burn mattresses of those who had been infected, the population was reminded of armed attacks (see also Oxfam, 2018a; IOAC, 2019b).

Communities resented the presence of response teams largely made up of security personnel and 'foreigners' (those from other countries or elsewhere in DRC). Many did not understand or agree with the side-lining of the local health system, including people they trusted for their medical needs (Congo Research Group, 2020). They also begrudged the oversized payments that 'foreign' workers received compared to typical salaries for the area (see also section 4.4). This overt monetisation of the response resulted in a widespread perception that MoH staff and non-Kivu Congolese were benefitting greatly, while few locals did.

Community resistance also stemmed from locals' perception of the relative threat posed by Ebola. From local communities' perspective, Ebola was more a priority for internationals and MoH response staff than for them. One MoH worker noted that the response had not understood, let alone confronted, the priority problems facing communities – namely, stopping violence from armed actors and improving basic services, such as roads, water and routine vaccinations.

In this difficult context, international leadership and coordination efforts around community engagement were sometimes well-intentioned but often fell short. The importance of community engagement was one of the main lessons coming out of the West Africa response (DuBois et al., 2015) – the leadership and key stakeholders in the EVD10 response were fully conscious of this (it was one of the nine key objectives in SRP 1 (DRC MoH, 2018a)). Although anthropologists were employed to mitigate issues around community misunderstandings and reluctance (IOAC, 2019a), many interviewees noted that their advice was not followed and reported unequivocally that community engagement was not taken seriously for many months. The initial lack of humanitarian agency involvement in the response – including experienced LNGOs[12] – resulted in less understanding among response leadership of community dynamics and less dialogue with voices who may have been able to offer strategies for building acceptance or correcting community engagement missteps. Many local actors described having been frozen out in the first few months and pointed to this as a missed opportunity that had repercussions for the following year and a half. This has been reiterated in a number of lessons-learned exercises, including those aiming to avoid the same mistakes in Covid-19 responses. One review noted that 'existing local community structures were not included at the beginning of the EVD response' and that 'the inclusion of traditional, religious, and political leaders was delayed' – emphasising that local structures and leaders represented the 'cornerstone of all community engagement activities' (Mobula et al., 2020: 15).

There were three further critical problems with the early community engagement strategies, according to interviewees and published analysis:

- Communications materials were linguistically and culturally inappropriate for the region, often written in French or standard Swahili instead of Congolese Swahili and other local languages and depicting images such as Western clothing and burial practices (Hasan, 2019; Kemp, 2020).
- Local health providers and community leaders were side-lined for international staff and

12 Some international staff interviewed for the study insisted that there were no humanitarian actors active in affected areas who might have contributed to the community acceptance side of the response. However, our interviews with LNGOs and local staff of INGOs revealed a fairly wide network of humanitarian actors – many of whom were conversant with international humanitarian coordination features, such as the cluster system and OCHA.

national doctors from Kinshasa who had never worked in a conflict setting and did not speak the local languages (Congo Research Group, 2020), thus alienating the local population. This parallel and 'foreign' structure also created confusion according to LNGO workers who said communities found it difficult to adapt to a new medical system with new staff.
- Community engagement was subordinated to a top-down medicalised approach that focused on risk communication – that is, directing community members in a paternalistic way to change their behaviour and emphasising the risks of Ebola – rather than focusing on two-way dialogue and shared ownership of the problem (Congo Research Group, 2020; Dewulf et al., 2020).

It was not until mid-2019 that community engagement approaches shifted meaningfully. As a result, communities began to accept the risks of Ebola, embrace their role in prevention and better understand and accept the external response structures. Several UN and INGO staff noted that a greater emphasis on community ownership 'only began in earnest in June 2019' – partly because UNICEF (who led on RCCE) had been unable to recruit and contract workers with the right skills quickly. At this time, the EERO also set up an access and acceptability working group to regularly review the interplay between community engagement, security and infections. This was reflected in SRP4, which pushed towards involving and strengthening local health structures and greater engagement with local organisations, religious leaders and humanitarian NGOs in an effort to introduce a more holistic approach that emphasised public health and humanitarian work alongside Ebola (DRC MoH, 2019b).

It is likely that this positive shift had begun earlier with SRP3, which took a marked move towards decentralised management and communication. For instance, 22 sub-coordination sites became active in affected areas, bringing the response closer to communities and increasingly engaging local health providers and leaders. Several local actors pointed to improvements beginning with SRP3, suggesting that they were quicker than international actors in implementing successful community engagement strategies.

Community engagement strategies employed during SRP3 included:

- *cellules d'animations communautaires* (community action cells, or CACs);
- *relais communautaire* (community health volunteers, or RECOs);
- an effective CDC-supported, IFRC real-time community feedback mechanism to track perceptions, priorities and needs;
- the work of the Social Science for Humanitarian Action Platform on trends, misinformation and political elements; and
- the establishment of the DRC-specific *Cellule d'Analyse en Science Social* (Social Science Research Unit, or CASS) on behaviours, perceptions and epidemiological trends (for more, see Dewulf et al., 2020).

Importantly, community information and priorities that had been gathered from the outset of the response began to be acted upon under the decentralised response model adopted in March/April 2019. Though CASS was funded by and originally supported UNICEF, many interviewees believed it was one of the best things to come out of the response and an example of good practice that should be replicated in future responses. All of these mechanisms have continued to be used in the Covid-19 pandemic.

4.2 Security approaches for an Ebola response in a conflict context

The 10th Ebola outbreak in DRC was the first Ebola outbreak in a conflict setting and, though protective security measures were necessary, there was a disproportionate reliance on large numbers of paid armed escorts. This reliance itself became a driver of insecurity and reinforced a cycle of conflict and resistance, as every attack that resisted response teams or threatened armed escorts further validated the need for armed escorts (Fairbanks, 2020). According to LNGO workers, the presence of the military caused armed groups to think they were being threatened, and left communities with

the impression that suspicious military or financial objectives were being pursued under the guise of a disease response. It is clear, though, that attacks and security incidents had their root not just in the Ebola response but in underlying issues endemic to the region. Indeed, Insecurity Insight (2020) attributed attacks against health care providers to lack of community trust, corruption and protracted conflict, all of which long predated the Ebola outbreak. That said, the security strategies pursued by the response likely inflamed and exacerbated existing tensions.

The response security strategy – defined by the government and followed by WHO and other response partners – relied heavily on armed escorts provided by the Armed Forces of the DRC (FARDC) and the Congolese National Police (PNC) – all receiving generous salary top-ups paid by the international response budget.[13] UN agencies with long experience operating in the DRC described using the PNC as 'a last resort'[14] and noted that the 'UN does not partner with the FARDC for anything'.

By most accounts, the security situation in some areas of the Grand-Nord affected by the outbreak amounted to the 'last resort' criteria employed by UN operational agencies in the DRC. Other areas were less risky;[15] yet, by and large, the leadership at the beginning of the response (following the government-defined policy) sent in security forces irrespective of the situation – 'almost a one-size-fits-all response in terms of security'. Security forces were used as a blanket protection measure, regardless of whether resistance was exhibited by communities or if it was manifested directly by armed groups. Little effort was made to share information on security between agencies or establish and follow common protocols. While this may have been sustainable in a response that lasted a month or two, it soon became clear to many respondents just how damaging the one-size-fits-all, militarised model would be (see also Lamoure and Juillard, 2020). From the beginning, a number of UN, INGO and local actors who had worked in the Ebola-affected areas as well as in other health emergencies in violent settings of DRC urged leadership to adopt a more nuanced security approach that would favour community engagement and 'access through acceptance' when possible. But they gained little traction in the response's first year, and response interventions were heavily militarised.

The lack of knowledge or contextual analysis of the region at the beginning of the outbreak greatly hampered the response's effectiveness, and many LNGO interviewees claimed that the outbreak lasted longer than expected because of the security situation. Local actors also disapproved of the government's approach because it contradicted the humanitarian principles of independence and neutrality. These armed groups were not considered neutral by communities, having been linked with violent offences in the past; the response leadership's use of them for security was seen as an implicit acceptance of their previous abuses (IOAC, 2019a; Congo Research Group, 2020). By contrast, other local actors interviewed saw the presence of the military and police as necessary, but not ideal, to prevent more medical teams from being kidnapped or killed.

MONUSCO, the UN's most credible security analyst and provider in DRC, was not fully engaged on security issues until the second half of the response, though they did attempt to share information from the Joint Mission Analysis Centre (JMAC) about armed groups with responders on the ground through official and unofficial channels. While MONUSCO was seen as having been an active participant in the conflict and therefore unlikely to be best

13 Major donors to the operation including US, UK and the World Bank did not allow their response contributions to directly finance national security actors. WHO covered these costs – at least from SRP1–SRP3 – through its core funding (which also comes largely from member state contributions).

14 'Last resort' refers to the widely shared principle among humanitarian actors to eschew armed escorts except when absolutely necessary; instead, humanitarian approaches call for security strategies that promote community acceptance and avoid perceptions of lack of neutrality or impartiality, especially in a conflict setting.

15 For an overview of the insecurity dynamics in the area at the beginning of the Ebola response, see SSHA (2018).

placed to provide direct support and logistics in the area (Oxfam, 2018b; SSHA, 2019b), several respondents saw a missed opportunity. According to them, MONUSCO's intelligence and analysis capacity could have been used to their advantage. UNDSS had an uneven presence in the area and did not mount a credible security management structure or strategy, which according to several interviewees was partly due to incompatibility of UN security approaches with the policies and practices adopted by the government and WHO.

The appointment of Gressly as EERC in mid-2019 brought a new focus on humanitarian security styles to some of the response. Fairbanks (2020: 45) describes humanitarian security risk management as including 'a strategic analysis of measures to prevent security incidents from occurring in the first place … an acceptance approach to security is pivotal'. Though JMAC remained an underused resource, the EERO did work with MONUSCO to create heat maps that showed differentiated security risks and acceptance levels within each health zone. According to EERO staff interviewed, the security measures introduced under Gressly helped reduce the security footprint of the response by relying on pre-positioning of forces and targeted, short-term deployments of rapid forces when needed. Yet, as one donor saw it, 'so much damage had been done they were always working against the legacy that had been left by initial decisions'.

A major frustration of WHO response leadership was their impression that the appointment of the EERC – whose mandate included the introduction of an integrated security strategy – resulted in no practical improvements towards a more conducive and secure environment for response activities. According to them, no progress was made by the EERC on this issue until February 2020, nine months after Gressly's appointment.

In practice, irrespective of actions taken by the EERO, the MoH and WHO largely maintained the same militarised security approach that they had initiated in the beginning of the response, which focused on managing daily risks without a coherent overall strategy or emphasis on acceptance. According to WHO staff, the speed and virulence of the disease did not afford them the luxury of pausing response interventions (or evacuating staff as some NGOs did) when security incidents occurred. They also pointed to ongoing attacks after the establishment of EERO as emblematic of why their security arrangements needed to be maintained.[16] According to a WHO internal document, more than $600,000 was going to national security services every month into early 2019, paid through its core budget.

4.3 Financial management of the response

Overall, it is estimated that between $800 million and $1.2 billion was spent during the 22 months of the 10th Ebola outbreak (see Table 2). 'That we don't have an overall figure on funding off the top of your head is indicative of the state of funding [management]', stated one donor. Another concurred: 'no one really knows what was spent [on the response] before SRP4'. Besides the US, which estimates it spent close to $600 million on the response (including on Ebola research and vaccines directly related to this outbreak),[17] other major donors included the World Bank (up to $300 million),[18] UK Department for International Development (DFID) (estimated $81.5 million),[19] the European

16 Insecurity Insight (2020) notes that, while the highest numbers of attacks occurred between February and May 2019, numbers did stay elevated through November 2019.

17 See www.hhs.gov/about/news/2020/06/25/hhs-secretary-azar-statement-end-eastern-drc-ebola-outbreak.html.

18 See www.worldbank.org/en/topic/pandemics/brief/fact-sheet-world-bank-support-to-10th-ebola-outbreak-in-democratic-republic-of-congo.

19 See https://devtracker.fcdo.gov.uk/projects/GB-GOV-1-300832.

Table 2: Estimated donor commitments and disbursements during the 10th Ebola outbreak

Pledge period	Commitments	Disbursements
SRP1	$43.8 million	$44.9 million
SRP2	$61.3 million	$61.4 million
SRP3	$147 million	$115 million
SRP4	$540 million	$506 million
Total	**$792.1 million**	**$727.3 million**
Non-SRP funds		**Disbursements**
US Government additional disbursements, not captured in Bank tracking sheets		$345.1 million*
Overall known total		**$1072.4 million**

* This includes an estimated $87 million during the period of SRP1 and SRP2, not reported through the government; $192.4 million research and development for drugs and vaccines; $8 million drug regulation; $21 million randomised drug trials; and $36.7 million technical expertise.

Note: Financing data for SRPs from World Bank tracking systems put in place under SRP4; additional information provided by donors. This table does not include resources/expenditures from the Red Cross movement, which were not captured through the SRPs or by the World Bank.

Union (EU) (estimated $120 million)[20] and Germany (estimated $20.5 million).[21]

By the standards of most urgent humanitarian aid interventions, the EVD 10 response was extremely well funded – and for the most part in a timely manner. SRP1 and SRP2 were fully funded. The SRP3 budget came under some pressure as donors held back resources to push for changes in leadership and coordination, but it was still resourced at almost 80% of needs. SRP4, likewise, was almost fully funded (94% of needs met) with the resource shortfalls mostly affecting the phase out/transition phase. This positive funding picture was based on a 'no regrets' policy among donors, instituted in part as a lesson learned from the West Africa Ebola outbreak (IOAC, 2019a). It allowed the government and WHO to move quickly with a major surge of staff and equipment, launching a substantial response within days of the first confirmed cases.

For many interviewees, however, there was 'too much money' in the response. The 'no regrets' approach may have been appropriate during the first weeks, but it should have been quickly revisited when it was clear that the outbreak was growing and would persist beyond three months. Response leadership at the outset (i.e. WHO in support of the government) had not established a clear and transparent funds management and accountability system for the response, which contributed to a perception of waste and lack of accountability. Several respondents described the financing of the response as a 'disaster' – a slow, cumbersome system with too much money, no accountability and no comprehensive or transparent picture of how much money was spent, who it was given to or how it was used. World Bank financing through the MoH – which, though they were not the largest donor to the overall response, was the highest to the MoH for this response – was described by experienced aid actors on the ground as exaggeratedly high. This was despite real efforts on the part of the World Bank to put in significant fiduciary controls.

For example, the Bank put in place specific measures over the course of the response to try and adapt to the emergency setting and address weaknesses as they came to light. It strengthened the capacity of its PDSS to contract with and

20 The EU estimate does not include in-kind technical expertise (e.g. ECDC and ECHO staff), in-kind logistics support through the EU Humanitarian Flight Service or $275 million in expenditures for Ebola research and vaccines since 2014. See: https://ec.europa.eu/echo/files/aid/countries/factsheets/thematic/wa_ebola_en.pdf.

21 For Germany, the estimate does not include contributions over the period to the WHO Contingency Fund for Emergencies, to the UN Central Emergency Fund, or to the ICRC. The proportion of these contributions that was directed to EVD 10 response is unknown.

oversee the implementation of the UN agencies' contracts and enforce agreed procedures related to specific eligible expenditures. It developed tools and templates to collect, review and act on key data from implementing agencies and partners in order to correct problems with the response. The Bank also worked with the government and partners as the response progressed to try to ensure greater harmonisation of hazard pay scales (including efforts to reduce pay scales during SRP4 and temporary suspensions of payments to certain partners), to rationalise the number of staff deployed and to ensure there was an integrated database to share information and data.

Though it took concrete corrective measures, the Bank exercised less than ideal oversight or controls on important spending practices (i.e. staffing levels, salaries and per diems, procurement) by its partner institutions, including WHO and the MoH. This was confirmed through interviews with several key informants who pointed to salaries and hazard pay for response staff (including payment to local health workers and MoH civil servants) as well as payments to community leaders as especially problematic, with 'no real accountability on these payments'. Payments to service providers with Bank resources were being made directly by the MoH and by WHO, UNICEF, WFP and IOM (via loan and grant agreements with the MoH). One informant described serious concerns of reputational risk reaching senior levels of the Bank, as it became clear that there were 'thousands of people; you didn't know where they were working, how they were selected, if they were capable' – many of whom were earning salaries or incentive payments multiple times higher than regular rates. There were also, according to key informants, reports of agency and government officials demanding kick-backs equivalent to 30% of future salary payments in return for recruitment – a practice consistent with aid experiences in other operations in DRC (Henze et al., 2020).

From the perspective of some interviewees, this lack of accountability was in part a result of global Bank–UN partnership arrangements that prohibit the Bank from more intrusive oversight – such as audits – of UN agencies that are recipients of funds. 'We could never get lists of those being paid by WHO [and to a lesser degree other UN agencies] because they knew there were all sorts of double payments happening', reported one key informant. Requests for information were 'always rebuffed by WHO based on the standard agreement with UN agencies'. The MoH, according to key informants, was also resistant to transparency with regard to its use of Bank funds for the Ebola response, and the Bank was reluctant to exert its leverage on the government in the midst of the outbreak. Finally, there was pressure on the Bank from other donors, agencies and the government to keep funds flowing for time-sensitive response activities – despite doubts about control systems. Looking back at the Bank's experience, one key informant concluded it had taken 'some time to understand that since we were providing money to UN agencies, we were also liable for what they were doing in the field'.

According to the Bank, their initial fiduciary arrangements around the response were designed with the assumption that the outbreak would be over within a short period. With discussions around the formulation of SRP4, beginning around February 2019, the Bank worked with UN agencies and other donors to achieve better financial management and accountability. This was reflected in the creation of a specific pillar focused on financial management within SRP4 (led by the Bank).

MoH officials were also aware that they did not have a good overview of where resources were going (one such official acknowledged that they never had the capacity to manage it). Several interviewees suggested that the 'no regrets' approach devolved into 'throwing money' at every newly encountered problem (thereby creating more problems) with no reflection on how poor resource management (or even the perception of poor resource management) undermines 'do no harm' principles. Indeed, the influx of cash into the response was a key driver of insecurity and prolonged the Ebola outbreak through the creation of an Ebola economy (see section 4.4). Its effects on community engagement and security are discussed above (see sections 4.1 and 4.2).

One of the key problems with the financing of the response was that there was no dedicated financial tracking and management capacity, though this had been a lesson 'learned' from

the West Africa response (Bali et al., 2019). This resulted in (1) a fragmented picture of overall donor support and its coherence with the government-led response; and (2) poor and non-accountable resource management systems in support of field operations. On the donor side, for example, one analysis of Ebola funding undertaken in December 2019 concluded, 'with regard to the U.S. specifically, there is limited information about how U.S. funding and efforts are coordinated with U.N. and DRC-led efforts' (Moss et al., 2019: n.p.). Many interviewees highlighted the absence of OCHA playing its traditional funds tracking role through its Financial Tracking Service (FTS) as a lost opportunity to bring an existing international coordination asset into the response. Later attempts to correct these shortcomings, such as the World Bank's leadership on Pillar 4 of SRP4 (aimed at strengthening financial planning, monitoring and reporting), were only partially successful, and the Bank was never able to assemble a complete summary of how much donor money was spent on the response due to limited or missing information from donors, the government and implementing partners.

Another problem – also identified in the West Africa response – was the slowness of financial and personnel management systems. In the West Africa response, Bali et al. (2019: 15) noted that 'the World Bank's grant-funding mechanisms were inadequate and overly complex for use in a public health emergency'. Although steps had been taken between 2014 and 2018 to correct these constraints, some interviewees wondered why the Bank had not established a more transparent and dedicated system for salary disbursements. One of the major operational constraints highlighted in the study's interviews was irregular and late payments of response provider salaries – sometimes resulting in strikes that froze critical activities. Many local staff interviewed reported that they are still waiting to be paid, months after the outbreak ended. In addition, the overall staffing of the operation was frequently cited as being inflated and rife with duplication (i.e. staff being hired and paid by multiple organisations and/or the government).

Two positive lessons around resource management from the West Africa response that were not adopted in the EVD 10 response might have helped address these shortcomings. First, a multi-donor trust fund for the West Africa response helped provide a transparent and inclusive financing mechanism for the UN Mission for Ebola Emergency Response (UNMEER). Second, the UN Development Programme (UNDP) took on responsibility for managing payrolls throughout the response – ensuring that a critical input for the operation of Ebola response teams was running smoothly. Other respondents in this study suggested that a global funding mechanism for disease outbreaks that is that is rapid, flexible, agile *and* inclusive of INGOs might also have improved the overall response and overcome some resource management shortcomings.

A perception of opaque and poor overall financial management of the response was also widely shared by LNGO staff and local leaders interviewed. Several local actors and provincial-level government employees were reticent to discuss how the response was financed, while almost all local actors interviewed felt they did not know how funds were managed, as their partnering organisations did not discuss this with them. LNGOs were not directly funded, but rather were funded as subcontractors of UN agencies, INGOs and the MoH. Many local actors saw these contracting arrangements as an extra layer of bureaucracy and another way for internationals and MoH staff to skim money off the response. These partner organisations often worked on a system of reimbursement, in which they first did the activities and then submitted invoices, leaving many smaller organisations out of pocket for up to six months as they waited to be paid.

Despite the enormous response budget, few long-term benefits for the health system or affected communities appear to have been left behind. Temporary ETCs were built with wood and tarpaulin, rather than permanent structures made of concrete. Vehicles were rented at enormous cost, rather than bought and left to the local health structures. Money was spent on handwashing tanks, which ran out of water, rather than installing taps that could have been used after the response was over. Other health objectives, such as childhood vaccinations, suffered as activities were temporarily suspended. During the Ebola response, a measles outbreak

in the area killed more children than there were deaths from Ebola (Kapur, 2020). Training and awareness on Ebola increased, but little durable infrastructure was created. According to numerous national and international interviewees, the ability of the health system to respond to a future outbreak is largely unchanged. The Congo Research Group (2020) points to the likelihood that future Ebola epidemics will again lead to parallel response structures unless a resilient Congolese health system is built up.

4.4 'Ebola business' and sexual exploitation and abuse

The introduction of a billion-dollar response into an area characterised by a complex humanitarian crisis where basic needs are perennially underfunded helped fuel real and perceived instances of waste, corruption and fraud, commonly referred to as 'Ebola business'. This also contributed to sexual exploitation and abuse (SEA) (SSHA, 2019b; Freudenthal, 2020; Henze et al., 2020; IASC, 2020). 'Ebola business' was a perception among affected communities that resources marshalled for the response inordinately benefitted authority figures and response providers rather than victims, survivors and their communities. The large sums of money were, as one UN worker described it, 'for businessmen in the area like Christmas had come to town, but there was nothing for the communities. And they would use threats or real violence against aid workers to make sure the money kept flowing'. Later attempts to take corrective measures to reduce waste, corruption and SEA were only partially successful.

Inflated payments for armed escorts, medical responders and community volunteers were cited by many as key components of the Ebola economy and served as a perverse incentive to continue the outbreak rather than end it. That the outbreak was deliberately stoked and/or the response debilitated in order to prolong 'Ebola business' was emphatically asserted in interviews, including with senior UN security and political officials. Payment levels to the PNC, FARDC and the DRC National Intelligence Agency (ANR) were set by the government and accepted by WHO, but they shocked UN leaders in country. Many respondents from the UN noted that WHO should have been transparent from the beginning about the financial arrangements made for security. While payments for security were necessary in the Grand-Nord, according to respondents, amounts defined by the government and funded by the international response were exaggerated, and any attempts to reduce these amounts could (and did) lead to violence. The murder in April 2019 of Dr Richard Valery Mouzoko Kiboung, a Cameroonian epidemiologist working with WHO, was linked by some respondents to delayed payments to armed groups during a period in the response (towards the end of SRP3) when money was tight. A recent independent review of corruption in DRC likewise reported that, according to their sources, 'this assassination targeted the Ebola response and those that represented a possibility to the reduction of circulating resources' (Henze et al., 2020: 12).

Rather than using local doctors and health systems, doctors from Kinshasa and other parts of DRC were brought in and paid significantly higher rates than local staff. As an INGO worker explained, 'I saw a doctor from Kinshasa getting $7,000 a month: $150 per day and what they called the Ebola allowance of $2,500. In the context of the country, a regular MoH employee doesn't receive a risk allowance. Doctors normally make between $600 and $800 a month, but some only make $300'. The discrepancy between payments for those providing regular medical care and those working in the Ebola response also caused health workers to leave their positions and join the response, leaving gaps in normal health coverage and destabilising communities both in Kinshasa and throughout the affected region. When local health systems were used, it was often done in ways that were detrimental to the system of the region. One INGO worker described how the provision of free drugs to primary care facilities upset staff because they could no longer charge patients for drugs and, according to this worker, it intensified the outbreak as people would crowd in the centres to get the drugs. Though some WHO staff scoffed at the idea of working through local health systems, especially at the beginning of

the response, most of the experienced medical NGO staff interviewed for this study felt it had been a mistake to side-line indigenous health capacities at the outset. Other analysts have also concluded that local health systems could have been put to better use during the 10th outbreak (Congo Research Group, 2020).

Some interviewees claimed that the lack of financial oversight allowed staff to collect salaries from more than one organisation and that many individuals on payment lists did not actually exist, while those who should have been paid had to wait months for their salaries, if they received them at all. Other corruption claims centred around the rates paid for rental accommodation for responders brought in from other countries and elsewhere in DRC as well as for the procurement of vehicle fleets at exorbitant rates benefitting elites (Henze et al., 2020), though several informants added the caveat that, if you wanted to act fast, you did not have a large choice from whom to hire dozens of vehicles.

Payments were also given to RECOs – often chosen because they were close friends or relatives, rather than experts in community engagement – whereas previously, volunteers used by the humanitarian community were unpaid (Dewulf et al., 2020). Other UN workers alleged that some agencies hired community advocates from armed groups, because they did not know the area or its dynamics. Payments to RECOs, as well as to medical responders and armed escorts, set a problematic precedent for future interventions in the country – and has subsequently been felt in the responses to the 11th outbreak and Covid-19.

The injection of large sums of money into the economy also led to a proliferation of bars and nightclubs to cater to the responders and an increase in transactional sex and SEA (Kapur, 2020). Several interviewees commented on how hotels that housed those working in the response also had rooms occupied by sex workers – suggesting this was not a coincidence. Other respondents – both international and local – claimed 'staff who had access to food and vaccines were asking for sexual favours for them' and that the employment of women in the response 'was very much based on sexual favours, was pretty much the standard procedure for how a woman would be hired, and determined her salary scale'. Similar claims have been made in the press, with women describing being propositioned by men, forced to have sex in exchange for work or fired when they refused (Flummerfelt and Peyton, 2020). According to local actors, a sizeable number of children, born to fathers who worked in the Ebola response, are now being cared for by single mothers. They are referred to as 'embola', or child 'of Ebola'. While some mechanisms for reporting SEA cases existed, according to a UN staff member versant in PSEA issues, victims would have needed electricity, access to the internet and literary skills in order to use them. There were also security and financial risks involved in reporting abuse. In the rare case when an allegation was made and an investigation launched, it would typically conclude that the 'rumours' were unsubstantiated or unproven, and no action would be taken.

Despite known risks for SEA and strong signals from key stakeholders of its prevalence, the issue did not receive sustained attention from leadership until the final months of the outbreak. In late 2018, the Deputy HC held meetings on PSEA but, according to interviewees, little changed, in part because the system that would have allowed allegations to be made and followed up on was not functional. PSEA was thus left to each individual organisation, and almost all international and local humanitarian actors interviewed for this study said their organisations had PSEA policies and codes of conduct in place. However, based on recent reporting, these policies and practices were not effective (Flummerfelt and Peyton, 2020). Further attempts to take corrective action through the establishment of a working PSEA network began in late October 2019 (Dewulf et al., 2020).

This lack of initial attention was, according to several interviewees, due to the response being seen as a public health rather than a humanitarian response. PSEA was not prioritised enough by either WHO or the MoH, particularly at the community level. The UN, for its part,

did not sufficiently staff, fund and utilise the existing in-country PSEA network[22] for the Ebola response. Even with the IASC scale-up and the turn towards a more humanitarian approach, PSEA continued to suffer from a lack of prioritisation and financing. Despite Gressly and the EERO advocating for funding and staffing for PSEA, the network that was finally established following the scale-up had 'so little capacity across the board that it was not surprising that it was not very effective', according to one donor – a sentiment shared by other staff responsible for PSEA measures. A common PSEA code of conduct was not agreed until early 2020 – almost a year and a half into the response – and was not widely shared, or signed, even then.

Several interviewees pointed to the overwhelming number of men involved in the response – in leadership and operational roles – as a key factor in the lack of attention given to PSEA. According to them, it was a 'male-dominated intervention' with no gender balance, and leadership positions were exclusively held by men. One UN worker remarked, 'If it's a male-led response, and women try to say something, you just don't get very far'.

22 The DRC has been a pilot site for an IASC PSEA Community-Based Complaint Mechanism since 2014. For more, see IASC (2016).

5 Unclear accountability: a public health emergency in a conflict context

The early decision by response leadership to treat EVD Outbreak 10 as a discrete public health crisis (or health security one) rather than a crisis-within-a-crisis – i.e. one health priority or threat to the community among many – set the tone for poor synergy between health and humanitarian actors that bedevilled the entirety of the response.

This separation was a mistake repeated from the West Africa response in 2014–2016. Although the West Africa outbreak did not occur in a context with a pre-existing humanitarian crisis, its scale spurred a subsequent humanitarian crisis. However, the response remained siloed as a health, rather than humanitarian, response (DuBois et al., 2015). WHO's interim assessment panel of the West African response noted with surprise that donors, government, the UN and INGOs either understood the humanitarian system or the health emergency system but not both. The panel recommended that WHO ensure its staff and partners had a better understanding of the humanitarian system and that OCHA ensure that the wider humanitarian community had a better understanding of the special nature of health risks (WHO, 2015). These lessons seem to have only been partially learned in the lead-up to the 10th response in DRC. Failing to insist on a more balanced health–humanitarian approach, according to one donor in DRC, was 'the bulk, the essence of the mistake that we made'.

Adopting a myopic, disease-specific approach also appeared to allow the health leadership of the response to skirt around important accountability issues that a broader public health or humanitarian conception of the response would have put at its centre. In particular, not putting greater emphasis on respecting humanitarian principles will likely have serious repercussions for future humanitarian work in the region, including future Ebola responses if the disease flares up again there. Not embracing a broader 'do no harm' or AAP approach also resulted in potentially avoidable instances of SEA and other corrosive effects of poorly managed resources (see chapter 4). Additionally, the parallel health structures established adversely impacted on existing health services available to the population. According to a multi-NGO lessons learned exercise in DRC following EVD 10, 'the single focus on one disease and purely Ebola-focused surveillance has led to a weakening of the health system and the epidemiological surveillance system for other notifiable diseases'.[23]

While a public health technical lead cannot be expected to also shoulder full accountability around operational, security, political and community engagement risks in a complex environment, it is unacceptable that accountability for these risks is so diffused that, in the end, no response leader, agency or coordination structure takes responsibility. In this case, WHO was determined not to cede real or perceived leadership and territory to a collective 'one UN' approach, even as its operational capacities were clearly challenged. At the same time, humanitarian activity and capacity in the affected zones was limited and took time to build up. Humanitarian agencies

23 'NGOs lessons learned on the Eastern Democratic Republic of the Congo Ebola outbreak' (2020): 30. Unpublished.

such as OCHA, UNICEF or UNFPA might also have acted more pro-actively from the outset to deploy capacity. As a result, a deliberate layering of the Ebola response within a larger public health and humanitarian response was never achieved, and accountability for important impacts of the response – beyond the eradication of the disease itself – remained undefined.

Over the course of the response, public health leaders gradually softened from a dogmatic, eradicate-the-disease attitude towards a more holistic approach that tapped into the capacities of important local and international humanitarian and development actors who brought complementary inputs. From a leadership and coordination perspective, the joint appointments of Gressly as the EERC and Dr Socé Fall on the WHO side, together with the elaboration of SRP4, helped accelerate this trend – along with the appointment of Dr Muyembe on the government side – but synergy was only ever partially achieved.

5.1 A disease-specific public health approach

According to many of the experts interviewed, the 10th Ebola response does not offer lessons for how to balance public health and humanitarian interventions because it functioned as a 'health security' rather than a public health intervention. This view was shared by WHO's IOAC, which midway through the crisis depicted a 'discrete health response' that had not successfully morphed into an 'integrated health and humanitarian response' (IOAC, 2019a: 30). Another analysis labelled the response 'the creation of a massive, parallel, disease-specific healthcare system' (Congo Research Group, 2020: 5). For these analysts and interviewees for this study, the EVD Outbreak 10 response instead raised questions about the suitability of a disease-focused model in the context of a complex humanitarian setting.

Interviews highlighted a strong impression among various agencies' staff that WHO's framing of the response from the outset (and, in the eyes of some, throughout the response) contributed to a false dichotomy: that efforts and structures designed to staunch and eliminate the disease were essentially incompatible with broader partnerships and structures (in this case with humanitarian actors) that might offer useful or necessary complementary inputs. This impression of being presented with a false dichotomy was echoed by medical INGO responders. One INGO leader described the MoH–WHO approach as 'treating the virus, not the population affected by it'. A true 'public health' response, noted an INGO worker, only began with the IASC scale-up, but by then it was too late to unwind or adapt the machinery built to attack the virus. Another medical NGO expert summarised the lack of synergy in the response as follows: 'the challenge of WHO taking over is it becomes a medically vertical response, so doesn't take advantage of any efficiencies of what's happening around it', such as how health or other cluster partners might scale up or adapt their work to help stop the outbreak.

One health INGO worker explained how their agency eventually achieved a fuller public health approach later in the response: 'You can't just give care for Ebola patients, but have to make sure that all of the population has access to primary and secondary health care. … When we worked in a full care centre, we could integrate a suspected Ebola patient more quietly there, and then if it wasn't Ebola, they would get care for whatever the problem was'. This type of approach would have also helped with the ongoing and simultaneous measles outbreak in the area (Kapur, 2020).

WHO staff interviewed also acknowledged it would have been preferable for the Ebola response to be layered with complementary activities that addressed the priority needs of communities. As one WHO respondent stated, 'Within a public health approach, we did identify community needs, but it is not WHO's role to construct bridges. Still, if we don't solve community needs more generally, we can't make the Ebola response work'. In practice, though, leadership – particularly on the government side – showed little patience for cultivating broader synergy with humanitarian actors. As described above, this was driven by a need to move quickly to treat the disease, and it was reinforced by their lack of familiarity – and impatience – with humanitarian coordination structures. For the most part, WHO staff who were interviewed lamented what they viewed as the shortcomings of humanitarian structures and the

reluctance of humanitarian agencies to proactively scale-up from the outset, rather than taking any responsibility for not having engaged in the cumbersome coordination work that might have brought about better synergy.

5.2 Subordinating humanitarian principles in a complex emergency setting

In the interest of controlling the virus quickly, the response leadership ignored humanitarian principles. According to one donor, an Ebola disease response such as this is about meeting goals, 'and you'll excuse lots of things on a no-regrets basis if it gets the job done'. Looking back at how the response evolved, a number of experienced Ebola response actors suggested that slowing down to better consider the context and the impact of the response itself – even with the risk of infections increasing in the short term – would have yielded better overall outcomes (fewer deaths and infections) over the long term. Others claimed that the time needed to consider and implement approaches consistent with humanitarian principles is incongruous with a response that is exclusively aimed at controlling the disease. From this perspective, slowing down the response might well have resulted in the disease spreading to surrounding countries and led to a completely new set of challenges. In fact, according to WHO staff, the organisation was guided in its approach – both by the International Health Regulations (IHR) Emergency Committee and the Strategic Advisory Group of Experts on Immunization (SAGE) – to maintain a focused health security approach based on this concern.[24]

In practice, there is nothing inconsistent with striving for a balance between speed/efficacy and respect for humanitarian principles – this is a dilemma in all urgent humanitarian crises that inevitably results in trade-offs. A number of interviewees, though, pointed to a general ignorance among WHO staff and MoH when it came to understanding or applying humanitarian principles. Even the widely adopted humanitarian exhortation to 'do no harm' was mentioned by several interviewees as being far better understood among humanitarian actors than health actors (despite it being derived from the Hippocratic oath). Many respondents noted that staffing so much of the response with medical doctors did not lend itself to a constructive mix of capacities and skillsets. Other humanitarian principles, such as neutrality and impartiality, were weakened when WHO and the MoH partnered with the FARDC (a recognised combatant engaged in a non-international armed conflict[25] – see section 4.2) and, as alleged by NGO medical staff interviewed, vaccination lists prepared by the response included political elites and their children. Similar suspicions about the misuse of vaccines, being 'biased towards those involved in the response and local political and economic elites … to the detriment of the broader population' were reported by community leaders in early 2019 (SSHA, 2019a: 3).

5.3 Missed opportunities for greater cooperation and accountability?

The UN model of leadership and coordination adopted for the Ebola response led to diffused accountability that, in practical terms, saw UN leadership 'hand off' responsibility to WHO in a complex, conflict environment, effectively divesting itself of responsibility and accountability. The health response, though, proved to be inseparable from the wider

24 Both the IHR Emergency Committee and SAGE held meetings on Ebola in October 2018. Readouts for those meetings can be found at www.who.int/news/item/17-10-2018-statement-on-the-meeting-of-the-ihr-emergency-committee-on-the-ebola-outbreak-in-drc and www.who.int/immunization/sage/meetings/2018/october/en/.

25 See RULAC (2019). Oxfam (2018b) notes that state security forces were responsible for more extrajudicial killings and summary executions between January and June 2018 in DRC than non-state armed groups.

development, humanitarian and peacebuilding challenges being confronted by the UN and other international actors working in eastern DRC. While WHO resisted a more deliberate, conflict-sensitive approach, UN leadership also stood on the side-lines for too long as the situation clearly deteriorated. As previously discussed, comparative strengths in the UN family – elements that could wed public health with complex emergency experience – were not realised until the elaboration of SRP4 and the appointment of the EERC.

The Congolese Red Cross, LNGOs and other medical NGOs in the area (e.g. Alima, Medair, Médecins Sans Frontières (MSF)) represented another potential area of synergy that was not fully utilised. NGO workers claimed they were initially excluded from meetings, and one mentioned how they were not allowed to get involved until 'one team member showed up at a meeting they weren't invited to and just stayed'. Yet others felt that NGOs also preferred a parallel structure, led by the HC, and did not want to work with WHO and the MoH. As one donor noted, 'some NGOs thought government was part of the problem, but they shouldn't confuse it with the MoH trying to implement the response on the ground'.

The majority of informants for this study highlighted the need for any health response in a conflict context to (1) keep the whole ecosystem of needs in mind, rather than maintain a strict focus on Ebola; (2) to strive to uphold humanitarian principles, rather than trample them in an attempt to work quickly; and (3) to complement ongoing work, rather than side-line it. While these objectives are true in all public health emergencies, they are particularly critical in complex emergencies.

5.4 Missed opportunities for lasting impacts?

Personnel interviewed from all sides of the response equation – government, international agencies, non-governmental, public health, development and humanitarian – all commented on the extraordinary budget mustered for a health security response[26] and lamented the lack of permanent infrastructure and capacity left behind, whether to improve overall health care or to respond to future Ebola outbreaks. Besides being an issue of cost-efficiency (see chapter 4), this was also a reflection of rigidity in donor funding as well as a failure of planning and imagination to embed a 'nexus' or developmental mindset into the operation. For international and national NGOs, neither the health security outcomes nor the later complementary humanitarian actions amounted to adequate accountability for so much money being spent with such little discernible longer-term positive impact for health care in the region.

A staff member from one leading medical INGO commented on returning to Equateur for the response to Outbreak 11:

> There is nothing on the ground that can be used. There is nothing left [from Outbreak 9]. We keep going in the same circle instead of thinking how to connect the present response to prepare for the future. Will we be constructing ETCs for every outbreak? Usually they happen in the same places. Do we have to start from scratch every time?

The 'nexus' shortcoming was also noted by development actors. One World Bank staff member said that, in retrospect, from the beginning of Outbreak 10:

> We should have insisted to work with local health staff … we should be working with local systems, creating

26 The US Government, for example, as the response's leading donor, provided $600 million over the 22 months of the outbreak, which represented 37.5% of its overall aid to health assistance in DRC ($1.6 billion) over the past 20 years: https://cd.usembassy.gov/together-we-stopped-ebola-in-the-east-together-we-can-advance-a-better-future-for-the-drc/.

> sustainability and building capacity. I visited some centres and it was a nightmare. On one side, you have millions of dollars coming from Ebola and on the other you have nothing. You have no education, no staff, no nurses, no facilities.

Government staff and LNGO workers interviewed were especially scathing in interviews about the lack of durable investment left behind by such a huge intervention. Others in the international community countered that the lack of stable and accountable governance systems in place meant that there were actually very few opportunities to pursue sustainable improvements in local health systems.

6 Going forward: context, accountability and principled action in future Ebola responses in complex settings

6.1 Summary lessons from previous outbreaks

This study has highlighted numerous lessons from previous Ebola outbreaks that positively shaped the 10th DRC response, including the effective and rapid surge capacity deployed by WHO. Lessons successfully applied on the medical intervention side were critical in overcoming the outbreak and demonstrating the blueprint for future responses, such as fast-tracking tests, vaccines and treatments, the quick turnaround of tests and the design of ETCs. Other lessons were applied unevenly, with leadership and coordination demonstrating inflexibility when it came to adapting response strategies to the specific context of the Grand-Nord. Table 3 summarises lessons from West Africa related to the focus areas of this study and the extent to which they were applied in the EVD 10 response.

6.2 Recommendations

The recommendations presented here cut across various elements of the 10th response, but they revolve around a common theme of adapting to context – specifically, the need to incorporate conscious planning and triggers for corrective action into EVD response models. Containing an outbreak in an area in the midst of a complex humanitarian crisis requires contingency planning for corrective action from the outset that draws on the full range of international assets available – UN, World Bank, donors, INGOs – in order to help support and shape a government-led response. The recommendations are also shaped by past lessons in other Ebola responses in DRC and West Africa that have yet to be fully applied by response actors.

6.2.1 Recommendations for international leadership and coordination

1. Leadership and coordination structures need to avail themselves of the assets, resources and knowledge in place in country from the outset. There is no room for a 'go-it-alone' approach in a complex setting. The UN RC/HC, with support from OCHA and WHO, should lead and unequivocally assume responsibility and accountability for future outbreak responses in complex emergency settings. The RC/HC is uniquely placed to draw on the full range of capacity and expertise in the country and across the international community. As with humanitarian responses, the RC/HC relies on collaboration among UN agencies, deferring on technical issues to the relevant agency – in the case of a public health emergency, to WHO. But overall guidance on the posture of the response – including

Table 3: Lessons applied from the West Africa outbreak to the EVD 10 response

Lesson from West Africa	Application in EVD 10 response
Leadership/coordination	
Establish an inter-agency mechanism for responding to health crises with multidimensional impacts.	Lesson partially applied. Mechanism established for course correction but employed late. Context-based triggers for activation not included in scale-up protocol.
Employ a single, unified governance structure, headed by a strong leader.	Lesson not applied. Establishment of empowered leadership delayed; two leaders appointed, resulting in confusion.
Use existing response mechanisms; avoid creating new structures.	Lesson not applied. OCHA side-lined; cluster system not activated. EERO established mid-outbreak.
Ensure diversity at the decision-making table.	Lesson partially applied. NGOs and other humanitarian actors, including local actors, not fully involved until late in response.
Declare an L3-level emergency in timely way.	Lesson not applied. Scale-up activated late.
Community engagement	
Put greater emphasis on strong and effective community engagement.	Lesson partially applied. Community engagement received inadequate attention and resources for many months; findings of social science research and perception surveys eventually used to tailor the response.
Build trust between responders and communities.	Lesson not applied. Response primarily top-down, medicalised, Ebola-specific; efforts focused on behaviour change, rather than two-way dialogue, trust and shared ownership.
Ensure a deliberate, consultative and inclusive response approach – particularly with regard to local health structures and communities.	Lesson partially applied but late.
Security	
Give sufficient attention to role of the security sector in health emergencies.	Lesson not applied. Inadequate attention given to risks/ consequences of armed actors on community resistance and other response dynamics.
Financial management	
Establish a revolving fund to finance the initial stages of an emergency response.	Lesson applied. WHO contingency funds released early, covering critical shortfalls.
Provide adequate funding on 'no regrets' basis to enable a quick response.	Lesson applied, though without timely review/adjustment of early spending decisions.
Develop partnerships with World Bank and others to mobilise financial support for international health regulations and emergency preparedness and support – including through establishment of Pandemic Emergency Financing Facility (PEF).	Lesson applied. World Bank funding mechanisms, including PEF, provided substantial funding.
Ensure dedicated financial tracking and management capacity.	Lesson not applied. No dedicated and transparent financial tracking or management capacity until late in the response.
Consider multi-donor trust funds to promote transparent and inclusive financing.	Lesson not applied. Resourcing and funding decisions not centralised in a transparent mechanism.
Ensure dedicated capacity, such as from UNDP, for managing payrolls and disbursements to responders.	Lesson not applied. Salaries paid late, if at all, and not streamlined through a single responsible agency.
Public health–humanitarian synergy	
Avoid a medicalised approach dominating the public health response; prioritise treatment alongside community sensitisation and contract tracing.	Lesson partially applied. Response was overly medicalised and Ebola-specific with re-balancing coming after significant amount of time elapsed.
Ensure clarity on roles and responsibilities, including robust measures for accountability.	Lesson partially applied. Accountability for combatting disease in place, but major gaps on other detrimental impacts of outbreak and response existed.
Employ a multi-sectoral approach to meet other priority needs.	Lesson partially applied. The second half of the response, starting with SRP4, brought a more fully holistic approach.

Source: This table format is borrowed in part from a table looking specifically at WHO lessons, as of mid-2019, in IOAC, 2019a. The summary lessons here are compiled from DuBois et al., 2015; Moon, 2015; WHO, 2015; UN, 2016; Bali et al., 2019; IOAC, 2019a; Lamoure and Juillard, 2020. The summary on applications of the lessons are derived from the case study.

on financial and security management – needs to come from the RC/HC. The RC/HC should be appropriately represented in technical coordination led by WHO. WHO lead technical staff should be appropriately represented in overall coordination structures led by the RC/HC.

2. WHO needs an improved response model to respond effectively in **fragile contexts** where governments either lack capacity and/or are parties to the conflict. This should be designed in conjunction with reviewing WHO's IMS system and ensuring optimal use of health cluster structures, with a view to ensuring flexibility and collaboration with partners in unpredictable contexts as well as the right mix of capacities and abilities in deployments.
3. Strengthening leadership and coordination capacity should be done based on existing structures – specifically the RC/HC office (possibly through a Deputy HC) and OCHA, including the cluster system. Parallel structures should be avoided. In exceptional circumstances or when the UN Country Team and HCT are overwhelmed with other crises in a country, the IASC Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events provides a solid basis for considering adjustments in leadership. The protocol should be understood to provide a road map for collective analysis and decision-making processes, but it will not always be strictly adhered to – especially on questions of overall leadership.
    a. In the case of the ad-hoc appointment of an outbreak coordinator, special effort should be made to appoint a leader who has relevant public health experience in addition to humanitarian and country coordination experience. WHO should broaden its pool of senior staff or potential senior incident managers to include this profile.
    b. WHO should also ensure that its representative posts in challenging and high-risk countries are filled, a pre-requisite for building effective partnerships with other agencies and the government. WHO should have a cadre within its emergency roster of people who could temporarily assume a Country Representative role if there is not an accredited Representative in place. This Representative would play a senior liaison role with the government on the emergency response as well as ensuring continuity for non-emergency health programmes, including in the response area.
    c. A dual-leadership model for an ad hoc response, as used in the creation of the EERT, should not be considered.
    d. An Operational Peer Review and Inter-Agency Humanitarian Evaluation as foreseen in the scale-up protocol should be standard practice.
4. The IASC Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events needs to be revised to ensure it is considered fully at an early stage and that its reconsideration is triggered whenever commonly agreed thresholds are reached:
    a. In the event of an outbreak occurring in the context of complex humanitarian crisis or in an area where state sovereignty is being actively contested, the 'scale-up' should be the default option.
    b. Thresholds that would later automatically trigger consideration of the scale-up could include:
        – the deterioration of the humanitarian situation in the outbreak area (e.g. the declaration in the area of an L3 emergency by any single UN agency; or the displacement of 100,000 or more people to or from the area);
        – a severe deterioration in security in the affected areas, such as direct armed attacks on response teams;
        – indicators suggestive of continued, uncontrolled growth of the outbreak, or insufficient response efficacy, such as:
            • trends in incidence or geographic expansion;
            • spread within urban or mobile populations and cross-border spread;
            • ability to establish response activities in new areas, average duration from symptom onset to isolation, proportion of new

cases previously listed as contacts and/or coverage of safe and dignified burials (the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC) or the Global Outbreak Alert and Response Network (GOARN) might make recommendations on these thresholds);
   - a simultaneous outbreak elsewhere in the country.
5. Operationalisation of the Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events should be improved through well-defined standby agreements – and possibly joint trainings – between WHO and key agencies with complementary capacities (e.g. WFP for logistics; UNICEF and IFRC for community engagement; OCHA for coordination and information/resource management; INGO platforms for operational surge capacity; IOM for population movements; and UNDP or World Bank for pooled funds and payroll management). Other specific preparedness actions on the part of partners could include support/responsibility for cold chain logistics, base camp support, treatment centres and IPC. Key partner NGOs need access to a pool of standby funds (possibly also for preparedness investments) – like those available to the major UN operational agencies – in order to deploy with size and speed. WHO should consider constituting a small inter-agency office to pursue and update these standby agreements and to serve as an inter-agency surveillance group for infectious disease threats. Some of these might be pursued by WHO through the global health cluster.
6. The World Bank should consider the appointment of a Bank 'Senior Emergency Coordinator' in future responses where Bank resources – whether channelled through governments or directly to implementing agencies – comprise a significant proportion of response funding. This Coordinator, independent of the sectoral area from which loans or grants are being made, should ensure that all Bank resources channelled to the response are aligned as much as possible with humanitarian principles and that exceptional capacity for due diligence is in place. The Coordinator could also play an explicit convening role in bringing together donors, governments and key operational agencies – at the request of, or in concert with, the UN Coordinator.
7. Following IASC guidance, a PSEA mechanism should be set up at the onset of an emergency response, adhere to the minimum operating standards and link to pre-existing mechanisms in country to avoid duplication and meet community needs (IASC, 2016). Moreover, a greater attempt at gender parity in both leadership of the response and operational roles is needed to ensure that greater attention is paid to gender issues, including SEA.

6.2.2 Recommendations for community engagement

1. Successful community engagement must be tailored to the specific context of the outbreak and anchored in local communities and community organisations, including existing health structures. WHO and its partners need to re-commit to community engagement that relies on two-way communication between the community and the response team. The fielding of anthropologists and political economy experts can help identify potential constraints and point to potential partners in the community, but response leadership needs to adapt according to the needs and concerns expressed by communities. This is a clear lesson learned from West Africa and other previous outbreaks, including at WHO, but it has yet to be sufficiently applied, suggesting that there needs to be a concerted effort within WHO to rebalance its response priorities and ensure adequate incentives (with staff or through budget allocations) to ensure it happens in future outbreaks.
2. Community engagement strategies need to embrace a broader AAP framework – that is, they need to go beyond addressing people's risk of contracting or spreading Ebola to considering their overall protection and well-being, including their other health needs.

An AAP approach complements the two-way communication mentioned above. Protection threats from the response itself – in particular, but not limited to, SEA – need to form an integral part of community engagement strategies and be given priority attention from response leadership and donors (through, for example, ensuring an AAP approach and the establishment of functioning PSEA mechanisms). The exigencies of an urgent public health response are not a justification for underplaying the collateral damage brought on by the response itself. More generally, a 'do no harm' analysis that goes beyond possible medical implications needs to be part of an infectious disease response strategy – especially in a complex humanitarian setting.

6.2.3 Recommendations for security

1. A more nuanced security approach, striving for 'security by acceptance' and opting only when necessary for 'security by protection', should be employed in future responses in complex settings. Sometimes these approaches will need to be pursued simultaneously. Security strategies should be built around conflict analysis, stakeholder mapping, networking and humanitarian and transactional negotiation in order to mitigate risks when armed escorts are needed.
2. The leadership and coordination of security efforts for the UN should be led by the expertise available in country (e.g. MONUSCO and UNDSS in DRC). UNDSS needs to be fully accountable for overall security arrangements in most instances (e.g. when a UN peacekeeping force is not present). When necessary, that expertise needs to be quickly scaled up. The use of armed escorts and their payment scales should be based strictly on policies agreed across the UN Country Team – WHO should not be managing security or acceding to inappropriate security arrangements set by the host country.

6.2.4 Recommendations for the management of resources

1. Future responses should establish from the outset systems to ensure transparent, accountable and efficient use of resources. Besides ensuring accountability for public resources, such systems are a prerequisite for gaining the trust of affected populations and communities. Future response should consider using a mutual accountability framework. Pooled fund mechanisms and dedicated financial tracking and management capacity (e.g. for staff employment and salary payments) – a lesson from the West Africa Ebola response – should be implemented.
2. Careful consideration should be given to the scale of payments made to communities to encourage their participation in a response, which in theory should be based on volunteerism or basic per diems at most (as is the case with Congolese Red Cross volunteers). Widespread and inflated payments in this response are likely to complicate future humanitarian action in the region – with reverberations already seen in Covid-19 activities and in the Outbreak 11 response.

6.2.5 Recommendations for balancing a public health and humanitarian response

1. WHO, as a public health technical lead, cannot be expected to also shoulder full accountability for the UN in a fragile, conflict-affected setting across a range of complex operational, security, political and community engagement issues. These lines of accountability – e.g. on security, appropriate PSEA mechanisms – need to be agreed to the extent possible at the outset of a response under the authority of the RC/HC, preferably as part of arrangements agreed during the early consideration of the Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events.
2. A true public health response aligns with the humanitarian principles of humanity, impartiality, neutrality and independence, as well as 'do no harm'. Both a public health response and a humanitarian response

should focus on the overall well-being of the individual, the family and the community and go beyond an exclusive focus on a specific disease and its eradication. WHO leadership and its incident management staff should be versant in the application of public health and humanitarian principles, as opposed to those of global health security, bearing in mind that there will always be a tension between aspiring to public health and humanitarian principles and the practical tasks of achieving a concrete outcome in a health emergency.

3. With the demonstrated effectiveness of treatments and vaccines for Ebola, future Ebola outbreaks should be dealt with as part of a community's overall health needs. Short-term 'global health security' fears – with outcomes designed around a focus on stopping the spread of the disease to the Global North – should be complemented by a focus on better and sustainable public health in DRC.

6.2.6 Recommendations to donors

1. Short-term earmarked funding from donors contributed to a situation where investments largely failed to put in place sustainable benefits for health systems in North Kivu (e.g. lasting structures or more resilience). Donors need to redouble their efforts to make humanitarian contributions more flexible and to make development financing accessible, in the context of ongoing financing efforts around the 'nexus' and localisation.
2. Donors need to reconsider the suitability of channelling resources through the World Bank for responses in complex humanitarian settings, especially when those same donors object to financing the government directly because of corruption or capacity worries.
3. Donors should continue to deploy staff to emergency responses in order to foster better understanding and communication between the donor community, the government and response agencies. But donors need to revisit their security protocols to ensure that their staff is deployed in the same locations as public health or humanitarian agency staff. An alternative would be to contract trusted third parties who are not subject to the same security constraints.

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Annex 1 Key research questions

Key question (KQ) 1. How effective are the different EVD response leadership and coordination mechanisms, with a focus on the EERO, EERC, EERT, WHO Incident Manager, and World Bank, and to what extent have they interfaced with the existing humanitarian coordination architecture and with other national coordination structures?
Judgement criteria (JC) 1.1. Clarity of roles, responsibilities and processes of different leadership and coordination mechanisms and their alignment to a common purpose during the response to the Ebola Virus Disease Outbreak 10.

Sub-questions
- What have been the primary EVD response leadership and coordination mechanisms? How have these evolved over time to adapt to changing needs?
- How have the EVD response leadership and coordination mechanisms (including national) worked together, both among themselves and with the humanitarian coordination architecture?

JC 1.2. The effectiveness of the leadership and coordination mechanisms during the response to the Ebola Virus Disease Outbreak 10, taking into account relevant operational limitations and constraints.

Sub-questions
- What have been the main strengths in the EVD response leadership and coordination mechanisms, bearing in mind their evolution over time? What have been the significant gaps and/or duplications?
- What have been the main strengths and weaknesses in the relationship/interaction between international response mechanisms and national coordination structures?
- What have been the underlying drivers for major successes and gaps? What have been the major obstacles and how have these been managed?

KQ 2. How have the EVD response leadership and coordination mechanisms affected outcomes for (a) community engagement and acceptance; (b) security approaches; and (c) financing, monitoring, and reporting on use of donor funds?
JC 2.1. EVD response leadership and coordination mechanisms have helped in identifying, analysing and managing risks relating to (a) community engagement and acceptance; (b) security approaches; and (c) financing, monitoring, and reporting on use of donor funds during the design and implementation of the response.

Sub-questions
- How have the EVD response leadership and coordination mechanisms – in their various iterations over the course of the response – helped in identifying, analysing and managing risks relating to (a) community engagement and acceptance; (b) security approaches; and (c) financing, monitoring, and reporting on use of donor funds?
- To what extent have these mechanisms improved or contributed to building resilience of community public health systems?

JC 2.2. Contribution of EVD response leadership and coordination mechanisms in achieving results (both planned and unexpected outcomes) for (a) community engagement and acceptance; (b) security approaches; and (c) financing, monitoring, and reporting on use of donor funds.

Sub-questions

- What have been the outcome targets for (a) community engagement and acceptance; (b) security approaches; and (c) financing, monitoring, and reporting on use of donor funds, and how have these been measured?
- What have been the planned and unexpected outcomes relating to (a) community engagement and acceptance; (b) security approaches; and (c) financing, monitoring, and reporting on use of donor funds?

KQ 3. In the context of an EVD outbreak taking place in a humanitarian setting and affecting communities experiencing conflict, what are the decision points for if/when/how to navigate from a public health emergency response to a humanitarian response or to harmonise the two approaches? What are the critical components of each approach that have contributed to an effective response?
JC 3.1. EVD response leadership and coordination mechanisms have been making timely, evidence-based decisions in consultation with the humanitarian coordination system using harmonised planning and monitoring systems and approaches.

Sub-questions

- How have EVD response leadership and coordination and humanitarian coordination systems made joint decisions? To what extent have the decisions been timely (i.e. at the right time) based on priority needs?
- What are some good practice examples? Have there been any key gaps? What are the main reasons for these successes and challenges?

JC 3.2. Public health and humanitarian agencies collaborated together using their comparative advantage.

Sub-question

- To what extent have been the comparative advantages of public health and humanitarian actors been optimised? What are some key examples and what were the underlying drivers for successes and/or shortfalls?

KQ 4. Should IASC consider revising the sections relating to leadership and coordination mechanisms in the 'Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events' and, if so, how?
JC 4.1. Protocols relating to leadership and coordination mechanisms in the IASC 'Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events' were applied and significantly influenced the response.

Sub-questions

- How were protocols relating to leadership and coordination mechanisms in the IASC 'Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events' used during different phases of the response?
- How did the use of these protocols influence the response?

JC 4.2. Examples of replicable good practice and areas for improvement/gaps in the existing protocols.

Sub-questions

- How did use of the protocols contribute positively to the response? Did agencies face significant challenges due to the use of the protocols? Why?
- Based on experiences during the response to EVD outbreak are there specific improvements needed in the protocols?

KQ 5. How did relevant lessons learned from the West Africa EVD outbreak (2014–2016) and prior DRC EVD outbreaks inform the response to DRC EVD Outbreak 10? Were there missed opportunities to apply previous lessons learned? What improvements are recommended to be able to respond more effectively next time there is a comparable crisis?

JC 5.1. Relevant learning from the West Africa EVD outbreak (2014–2016) and prior DRC EVD outbreaks was used during the response to DRC EVD Outbreak 10.

Sub-questions

- Which lessons from previous EVD outbreaks were applied to the DRC EVD Outbreak 10?
- How were these lessons applied and what was the result? Were there any lessons that weren't applied that should have been? If so, why?

JC 5.2. Examples of lessons learned from previous EVD outbreaks and/or from the current EVD outbreak that could help to improve the response to comparable crises in future.

Sub-questions

- What were the key obstacles, gaps and deficiencies in this response that should be taken into account in order to improve future responses?
- What should be done differently next time there is a comparable outbreak in the areas of: leadership/coordination mechanisms; managing risks; engaging communities; in balancing/ harmonising a public health emergency response with a humanitarian response; and in incorporating learning from previous responses? What specific recommendations might improve these areas in future responses, including the inter-relationship between coordination, community engagement and acceptance?

HPG

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Cover photo: A doctor puts on personal protective equipment in January 2019 in Beni, North Kivu region of DRC. Credit: World Bank/Vincent Tremeau

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